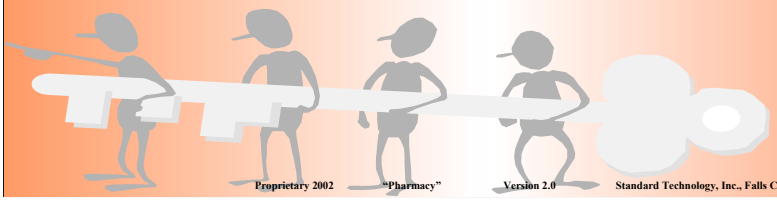
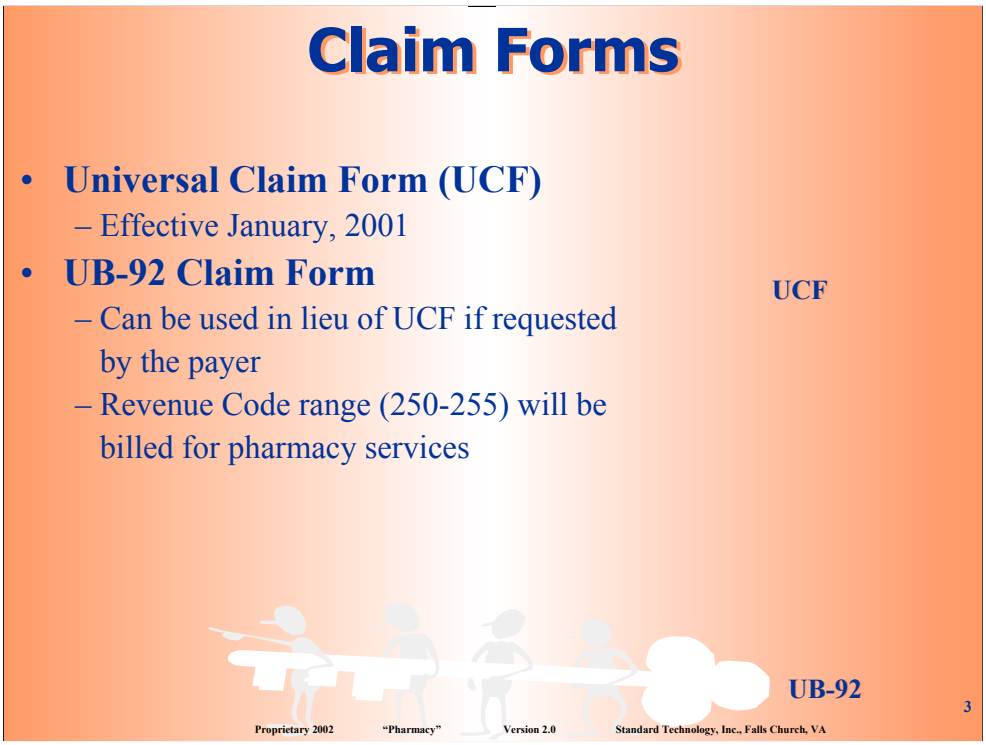
Uniform Business Office
Outpatient Itemized Billing Training Course

PHARMACY



Objectives

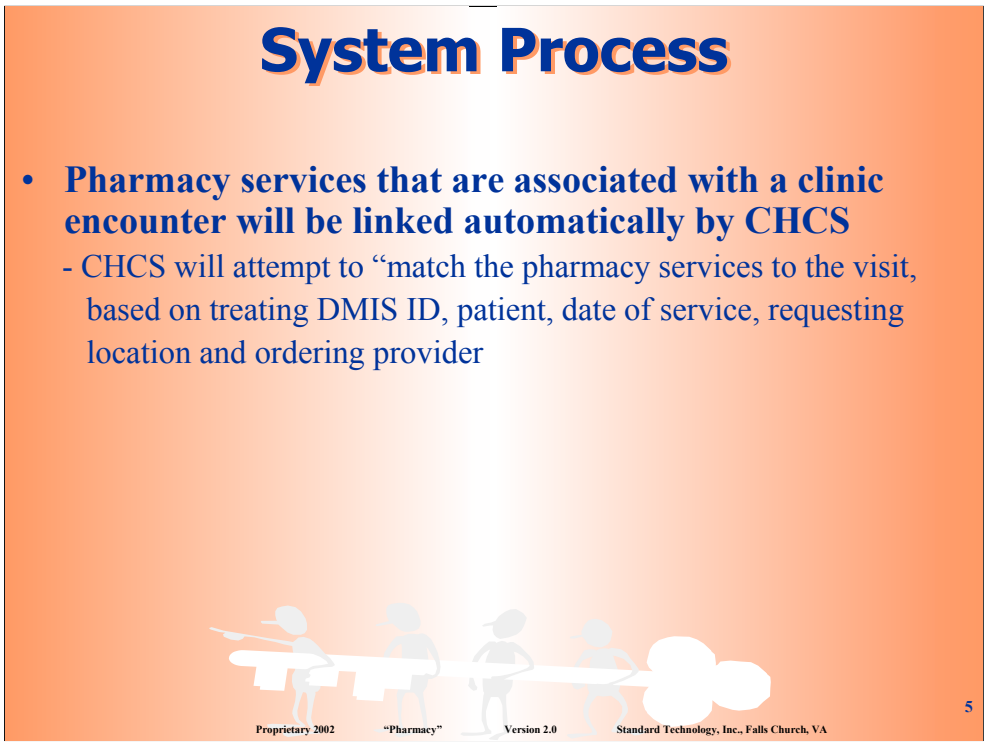
- Discuss the claim forms used for pharmacy billing
- Explain the pharmacy billing procedures for Outpatient Itemized Billing (OIB)
- Describe the system process for pharmacy billing
- Explain the pharmacy billing requirements



- **The use of the UCF is mandatory unless a documented request is made by the payer.**

Billing Procedures

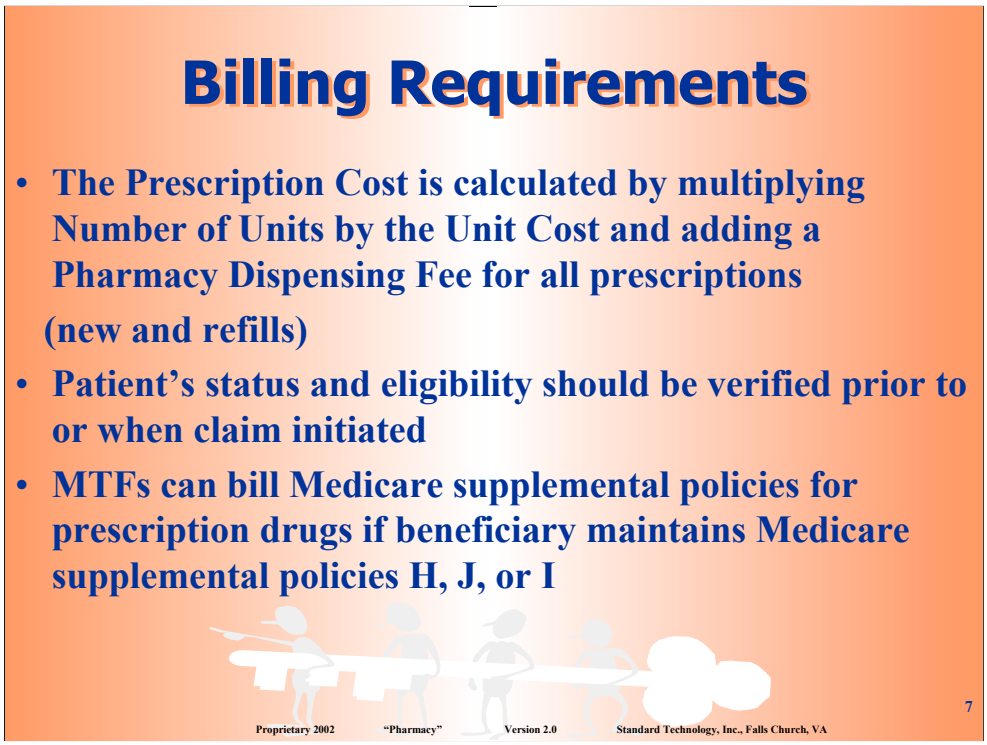
- **All prescriptions (new and refills) including internal (clinic visits) and external will be submitted to third party payer if pharmacy OHI exists for DoD beneficiary**
  - Applies to:
    - MSA and MAC
    - I&R and DD7A



- **Pharmacy services that are associated with a clinic encounter will be linked automatically by CHCS:**
  - The Ordering Provider enters the order within CHCS Order Entry and responds to the prompt "Are these orders associated with this patient appointment?"
- **Otherwise, CHCS will attempt to "match" the pharmacy services to the visit, based on Treating DMIS ID, Patient, Date of Service, Requesting Location and Ordering Provider:**
  - All of these fields must match exactly for CHCS to automatically match the ancillary to the encounter.

Billing Requirements

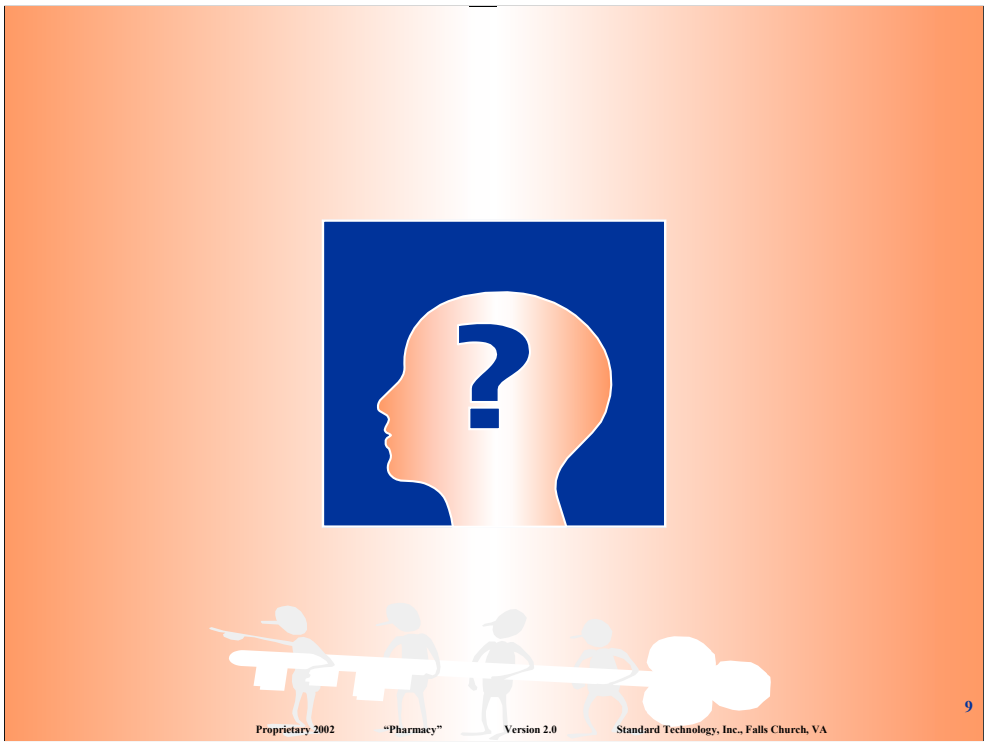
- Facilities must obtain and provide a National Council for Prescription Drugs Program (NCPDP) ID Number for claims processing when required by payer
- For specific pharmaceutical services, supportive medical record documentation must be submitted with claim
- Unit of issue indicated by provider in CHCS file must be consistent with unit of issue in Pharmacy Rate Table



- **Prescription Cost = (# of Units x Unit Cost + Pharmacy Dispensing Fee)**
  - **Example:**
    - # of Units = **20**
    - Unit Cost = **$0.21**
    - Dis. Fee = **$6.00**
      - 20 x $0.21 = **$4.20**
      - $4.20 + $6.00 = **$10.20**
- **Unit cost is now based on the actual cost per NDC Number. Previous rates were calculated based on the lowest generic cost per drug.**
- **MTFs can bill Medicare supplemental policies for prescription drugs if beneficiary maintains Medicare supplemental policies H, J, or I:**
  - This only applies to billing for prescriptions ordered by an external provider (FC accounts only).
  - There will be a separate bill for prescriptions ordered in conjunction with an outpatient encounter.

Missing Rates

- **If there is no corresponding rate for the same medication, dosage, and strength in the Pharmacy Rate Table, that particular drug cannot be billed**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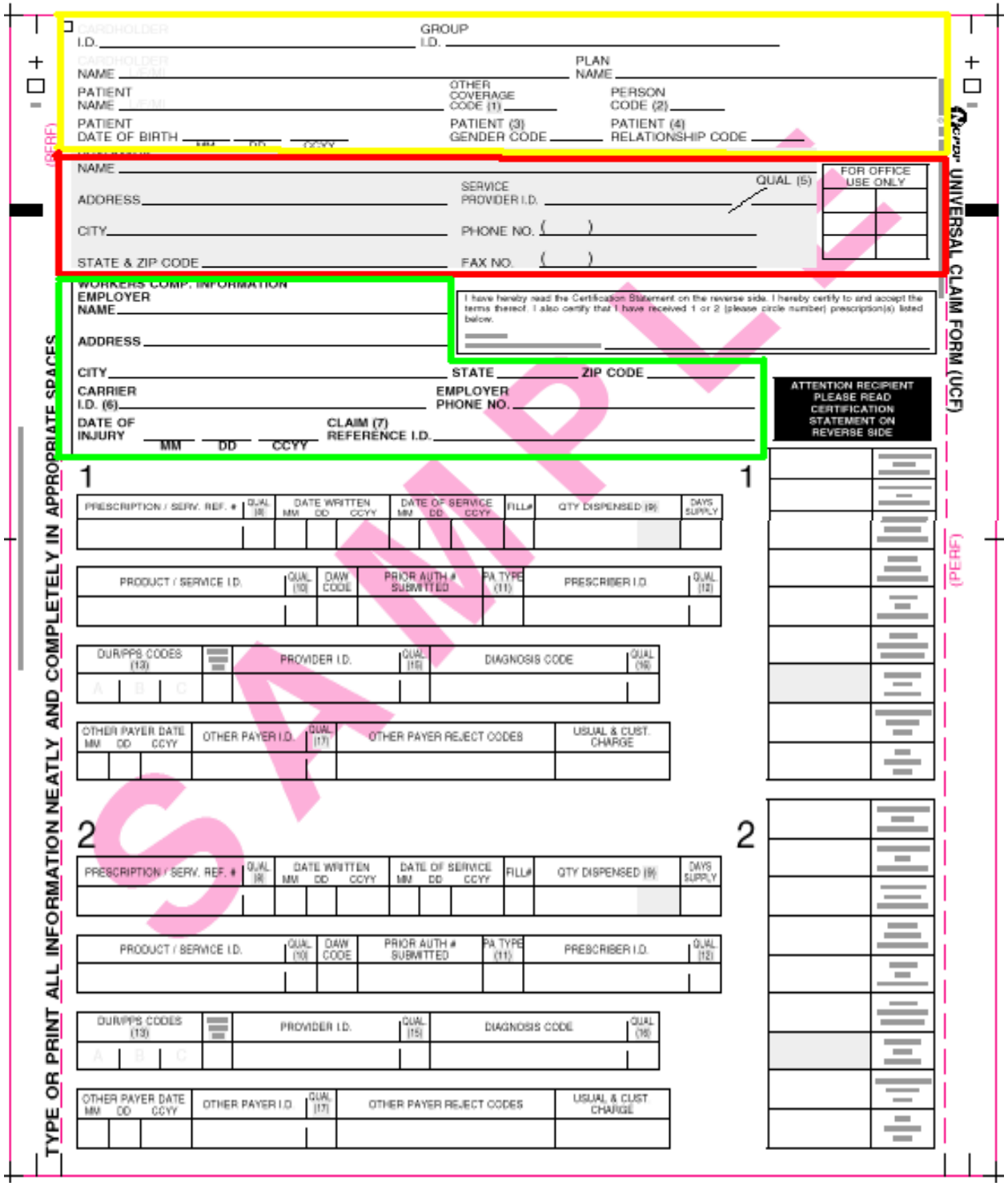
Universal Claim Form Example



Universal Claim Form Example

IMPORTANT I certify that the patient information entered on the front side of this form is correct, that the patient named is eligible for the benefits and that I have received the medication described. If this claim is for a workers compensation injury, the appropriate section on the front side has been completed. I hereby assign the provider pharmacy any payment due pursuant to this transaction and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to this claim to the plan administrator, underwriter, sponsor, policyholder and the employer.

PLEASE SIGN CERTIFICATION ON FRONT SIDE FOR PRESCRIPTION(S) RECEIVED

INSTRUCTIONS

1. Fill in all applicable areas on the front of this form.
2. Enter COMPOUND RX in the Product Service ID area(s) and list each ingredient, name, NDC, quantity, and cost in the area below. Please use a separate claim form for each compound prescription.
3. Worker's Comp. Information is conditional. It should be completed only for a Workers Comp. Claim.
4. Report diagnosis code and qualifier related to prescription (limit 1 per prescription).
5. Limit 1 set of DUR/PPS codes per claim.

DEFINITIONS / VALUES

1. OTHER COVERAGE CODE

0=Not Specified
1=No other coverage identified
2=Other coverage exists-payment collected
3=Other coverage exists-this claim not covered
4=Other coverage exists-payment not collected
5=Managed care plan denial
6=Other coverage denied-not a participating provider
7=Other coverage exists-not in effect at time of service
8=Claim is billing for a copay

2. PERSON CODE: Code assigned to a specific person within a family.

3. PATIENT GENDER CODE

0=Not Specified
1=Male
2=Female

4. PATIENT RELATIONSHIP CODE

0=Not Specified
1=Cardholder
2=Spouse
3=Child
4=Other

5. SERVICE PROVIDER ID QUALIFIER

Blank=Not Specified
01=National Provider Identifier (NPI)
02=Blue Cross
03=Blue Shield
04=Medicare
05=Medicaid
06=UPIN
07=NCPDP Provider ID
08=State License
09=Champus
10=Health Industry Number (HIN)
11=Federal Tax ID
12=Drug Enforcement Administration (DEA)
13=State Issued
14=Plan Specific
99=Other

6. CARRIER ID: Carrier code assigned in Worker's Compensation Program.

7. CLAIM/REFERENCE ID: Identifies the claim number assigned by Worker's Compensation Program.

8. PRESCRIPTION/SERVICE REFERENCE # QUALIFIER

Blank=Not Specified
1=Rx billing
2=Service billing

9. QUANTITY DISPENSED: Quantity dispensed expressed in metric decimal units (shaded areas for decimal values).

10. PRODUCT/SERVICE ID QUALIFIER: Code qualifying the value in Product/Service ID (407-07)

Blank=Not Specified
00=Not Specified
01=Universal Product Code (UPC)
02=Health Related Item (HRI)
03=National Drug Code (NDC)
04=Universal Product Number (UPN)
05=Department of Defense (DOD)
06=Drug Use Review/Professional Pharm. Service (DUR/PPS)
07=Common Procedure Terminology (CPT4)
08=Common Procedure Terminology (CPT5)
09=HCFA Common Procedural Coding System (HCPCS)
10=Pharmacy Practice Activity Classification (PPAC)
11=National Pharmaceutical Product Interface Code (NAPPI)
12=International Article Numbering System (EAN)
13=Drug Identification Number (DIN)
99=Other

11. PRIOR AUTHORIZATION TYPE CODE

0=Not Specified
1=Prior authorization
2=Medical Certification
3=EPSDT (Early Periodic Screening Diagnosis Treatment)
4=Exemption from copay
5=Exemption from Rx limits
6=Family Planning Indicator
7=Aid to Families with Dependent Children (AFDC)
8=Payer Defined Exemption

12. PRESCRIBER ID QUALIFIER: Use service provider ID values.

13. DUR/PROFESSIONAL SERVICE CODES: Reason for Service, Professional Service Code, and Result of Service. For values refer to current NCPDP data dictionary.

A=Reason for Service
B=Professional Service Code
C=Result of Service

14. BASIS OF COST DETERMINATION

Blank=Not Specified
00=Not Specified
01=AWP (Average Wholesale Price)
02=Local Wholesaler
03=Direct
04=EAC (Estimated Acquisition Cost)
05=Acquisition
06=MAC (Maximum Allowable Cost)
07=Usual & Customary
09=Other

15. PROVIDER ID QUALIFIER

Blank=Not Specified
01=Drug Enforcement Administration (DEA)
02=State License
03=Social Security Number (SSN)
04=Name
05=National Provider Identifier (NPI)
06=Health Industry Number (HIN)
07=State Issued
99=Other

16. DIAGNOSIS CODE QUALIFIER

Blank=Not Specified
00=Not Specified
01=International Classification of Diseases (ICD9)
02=International Classification of Diseases (ICD10)
03=National Criteria Care Institute (NDCC)
04=Systemized Nomenclature of Human and Veterinary Medicine (SNOMED)
05=Common Dental Term (CDT)
06=Medi-Span Diagnosis Code
07=
99=Other

17. OTHER PAYER ID QUALIFIER

Blank=Not Specified
01=National Payer ID
02=Health Industry Number (HIN)
03=Bank Information Number (BIN)
04=National Association of Insurance Commissioners (NAIC)
09=Coupon
99=Other

COMPOUND PRESCRIPTIONS - LIMIT 1 COMPOUND PRESCRIPTION PER CLAIM FORM.

Name	NDC	Quantity	Cost

Universal Claim Form (UCF) Instructions

Patient Information
This section of the Universal Claim Form provides the patient and cardholder information.

Cardholder I.D.
DoD Format Requirements: **Required**
Enter the cardholder's I.D

Group I.D.
DoD Format Requirements: Conditional
Enter the group I.D.

Cardholder Name
DoD Format Requirements: **Required**
Enter the cardholder's name (last, first, middle initial).

Plan Name
DoD Format Requirements: **Required**
Enter plan name.

Patient Name
DoD Format Requirements: **Required**
Enter the patient's name (last, first, middle initial).

(1)– Other Coverage Code
DoD Format Requirements: **Required**
Enter other coverage codes, as applicable.

0 – Not Specified **(Default)**
1 – No other coverage identified
2 – Other coverage exists-payment collected
3 – Other coverage exists-this claim not covered
4 – Other coverage exists-payment not collected
5– Managed care plan-denial
6– Other coverage denied-not a participating provider
7– Other coverage exists-not in effect at this time
8– Claim is billing for a co-pay

(2) – Person Code
DoD Format Requirements: **Required**
Code assigned to specific person in the family
**Proposed FMP

Universal Claim Form (UCF) Instructions

Patient Date of Birth
DoD Format Requirements: **Required**
Enter the patient's DOB three spaces MM DD CCYY

(3) – Patient Gender Code
DoD Format Requirements: **Required**
Enter the correct gender code.

0 – Not Specified
1 – Male
2 – Female

(4) – Patient Relationship Code
DoD Format Requirements: **Required**
Enter the relationship code of patient to cardholder. (Drop down box)

0 – Not specified
1 – Cardholder
2 – Spouse
3 – Child
4 - Other

Pharmacy Information
This section of the Universal Claim Form provides the pharmacy information required for processing the claim.

Pharmacy Name
DoD Format Requirements: **Required**
Enter the Name of the Pharmacy. *For DoD,* ***enter the Name of the MTF*** *that filled the prescription.*

(5) – Service Provider I.D./ Qualifier Code
DoD Format Requirements: **Required**
**Proposed NCPDP provider ID

Enter the ID of the service provider/ followed by the following qualifier code.
** Proposed 07 – NCPDP provider ID

Blank – Not Specified
01 – National Provider Identifier (NPI)
02 – Blue Cross
03 – Blue Shield
04 – Medicare
05 – Medicaid
- Future Proposal to NUBC will be to allow DoD to use the MTF DMIS ID as the NPI.

06 – UPIN
- Current proposal will allow DOD000 to be used as the UPIN on the UB-92.

07 – NCPDP Provider ID
08 – State License
09 - CHAMPUS
10 -Health Industry Number
11 -Federal Tax ID
12 -DEA

Address
DoD Format Requirements: **Required**
Enter the pharmacy's street address. *For DoD, **enter the Address of the MTF** that filled the prescription.*

Phone Number
DoD Format Requirements: **Required**
Enter the pharmacy phone number. *For DoD, **enter the Telephone Number of the MTF** that filled the prescription.*

City
DoD Format Requirements: **Required**
Enter city for pharmacy address. *For DoD, **enter the City of the MTF** that filled the prescription.*

Fax No.
DoD Format Requirements: **Required**
Enter the fax # for the pharmacy. *For DoD, **enter the FAX Number of the MTF** that filled the prescription.*

State and Zip Code
DoD Format Requirements: **Required**
Enter state and zip code for pharmacy. *For DoD, **enter the State and Zip Code of the MTF** that filled the prescription.*

Workers Compensation Information
This section provides information related to Worker Compensation claims

Employer Name
DoD Format Requirements: Conditional
Enter the employer's name for the patient

Address
DoD Format Requirements: Conditional
Enter the employer's street address.

City
DoD Format Requirements: Conditional

Enter employer's city.

State
DoD Format Requirements: Conditional
Enter the employer's street state.

Zip
DoD Format Requirements: **Required**
Enter employer's zip.

Authorized Signature
DoD Format Requirements: **Required**
Obtain authorized signature of patient or legal guardian. (handwritten)

(6) – Carrier I.D.
DoD Format Requirements: **Required**
Enter the I.D. of the carrier.
Code assigned to Worker's Compensation Program
(Worker's Comp information is conditional and should be reported only for Workers Comp claims.)

Employer Phone Number
DoD Format Requirements: **Required**
Enter the employer's phone number.

Date of Injury
DoD Format Requirements: **Required**
Enter date of injury (3 spaces MM DD CCYY).

(7) – Claim Reference I.D.
DoD Format Requirements: **Required**
Enter the reference ID for the claim.
Claim number assigned by Workers Compensation Program

Prescription/Service Information
Sections 1 and 2 of the Universal Claim Form require the same data. The form provides for two separate prescriptions to be filed on one claim form.

Prescription/Service Reference Number
DoD Format Requirements: Required
Enter the prescription or service reference #

(8) – Prescription/Service Reference Number Qualifier
DoD Format Requirements: **Required**
**Proposed drop down box

Enter the qualifier code.
Blank – Not specified
1 – Rx Billing **(Default)**
2 – Service Billing

Date Written
DoD Format Requirements: **Required**
Enter date prescription or service written. MM | DD | CCYY

Date of Service
DoD Format Requirements: Required
Enter the dispensed date.

Fill Number
DoD Format Requirements: Required, if applicable
Enter fill number for the prescription.

(9) – Quantity Dispensed
DoD Format Requirements: Required, if applicable
Enter the quantity of prescription dispensed.
Quantity dispensed expressed in metric decimal units.

Days Supply
DoD Format Requirements: Required, if applicable
Enter the number of days supplied in prescription.

Product Service ID
DoD Format Requirements: Required, if applicable
Enter product/service ID number. (Currently, will default to the NDC number)

(10) – Product Service ID Qualifier
DoD Format Requirements: **Required**
Enter the appropriate qualifier code.
Blank – Not specified
00 – Not Specified
01 – Universal Product Code (UPC)
02 – Health Related Item (HRI)
03 – National Drug Code (NDC) **(Default)**
04 – Universal Product Number (UPN)
05 – Department of Defense (DoD)
06 – Drug Use Review/Professional Pharmacy Service (DUR/PPS)
07 – CPT4
08 – CPT5
09 -HCPCS
10 - Pharmacy Practice Activity Classification (PPAC)
11 - National Pharmaceutical Product Interface Code (NAPPI)

12 - International Article Numbering System (EAN)
13 – Drug Identification Number (DIN)
99 – Other

Dispensed As Written (DAW) Code
DoD Format Requirements: Not Required (Blank)
Enter the DAW code.

Prior Authorization Number Submitted
DoD Format Requirements: Conditional
Enter the prior authorization # submitted.

(11) – Prior Authorization Type
DoD Format Requirements: Conditional
**Proposed Not specified

Enter the Prior Authorization Code.
0 – Not Specified **(Default)**
1 – Prior Authorization
2 – Medical Certification
3 – EPSDT – Early Periodic Screening Diagnosis Treatment
4 - Exemption from Co-pay
5 - Exemption from RX limit
6 - Family Planning Indicator
7 - Aid to Families with Dependent Children (AFDC)
8 - Payer Defined Exemption

Prescriber ID
DoD Format Requirements: **Required**
Enter the name of the provider that prescribed the drug.

(12) – Prescriber ID Qualifier
DoD Format Requirements: **Required**
Blank – Not specified
00 – Not specified
01 – DEA
02 – State License
03 – SSN
04 – Name **(Default)**
05 – National Provider ID (NPI)
06 – Health Industry Number (HIN)
07 – State Issued
99 – Other

99 for other if enter provider name

(13) – DUR/PPS Codes
DoD Format Requirements: Conditional
Enter the PPS codes – (Limit 1 set of DUR/PPS codes per claim)

A – Reason for Service
B – Professional Service Code
C – Result of Service

(14) – Basis Cost
DoD Format Requirements: Required
**Proposed Direct

Enter the Basis Cost.

Blank – Not specified
00 – Not specified
01 – Average Wholesale Price (AWP)
02 – Local Wholesale
03 – Direct **(Default)**
04 – Estimated Acquisition Cost (EAC)
05 – Acquisition
06 – MAC (Maximum Allowable Cost)
07 – Usual and Customary
09 - Other

Provider ID (Registered Pharmacist, R.P.H.)
DoD Format Requirements: **Required**
Enter the provider's ID

(15) – Provider ID Qualifier
DoD Format Requirements: **Required**
Enter the qualifier.

Blank – Not specified
00 – Not specified
01 – DEA
02 – State License
03 – SSN
04 – Name
05 – National Provider ID (NPI)
06 – Health Industry Number (HIN)
07 – State Issued
99 – Other **(Default)**

Diagnosis Code
DoD Format Requirements: **Conditional**
Enter the ICD9-CM diagnosis code.

(16) – Diagnosis Code Qualifier
DoD Format Requirements: **Conditional**
**Proposed ICD-9

Enter the qualifier.
(Report diagnosis code and qualifier related to prescription – limit: one per prescription)
Blank – Not Specified
00 – Not Specified
01 – ICD-9 **(Default)**
02 – ICD-10
03 – National Criteria Care Institute (NDCC)
04 – Systemized Nomenclature of Human and Veterinary Medicine (SNOMED)
05 – Common Dental Terminology
06 – Medi-Span Diagnosis Code
07 – American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM-IV)
99 – Other

Other Payer Date
DoD Format Requirements: Conditional
Enter the other payer date.

Other Payer ID
DoD Format Requirements: Conditional
Enter ID for other payer.

(17) – Other Payer ID Qualifier
DoD Format Requirements: Conditional
Blank – Not Specified
01 – National Payer ID **(Default)**
02 – Health Industry Number (HIN)
03 – Bank Information Number (BIN)
04 – National Association of Insurance Commissioners (NAIC)
05 – Coupon
99 – Other

Other Payer Reject Codes
DoD Format Requirements: Conditional
Enter reject codes from other payer.

Usual and Customary Charge
DoD Format Requirements: **Required**
Enter the Usual and Customary Rate.

Ingredient Cost Submitted

DoD Format Requirements: **Required**
Enter the ingredient cost per unit. (Total cost of the drug not including the dispensing fee.)

Dispensing Fee Submitted
DoD Format Requirements: **Required**
Enter the dispensing fee. **(Default = 6.00)**

Incentive Amount Submitted
DoD Format Requirements: Conditional
Enter any incentive charges. **(Default = 0.00)**

Other Amount Submitted
DoD Format Requirements: Conditional
Enter any other charges submitted.

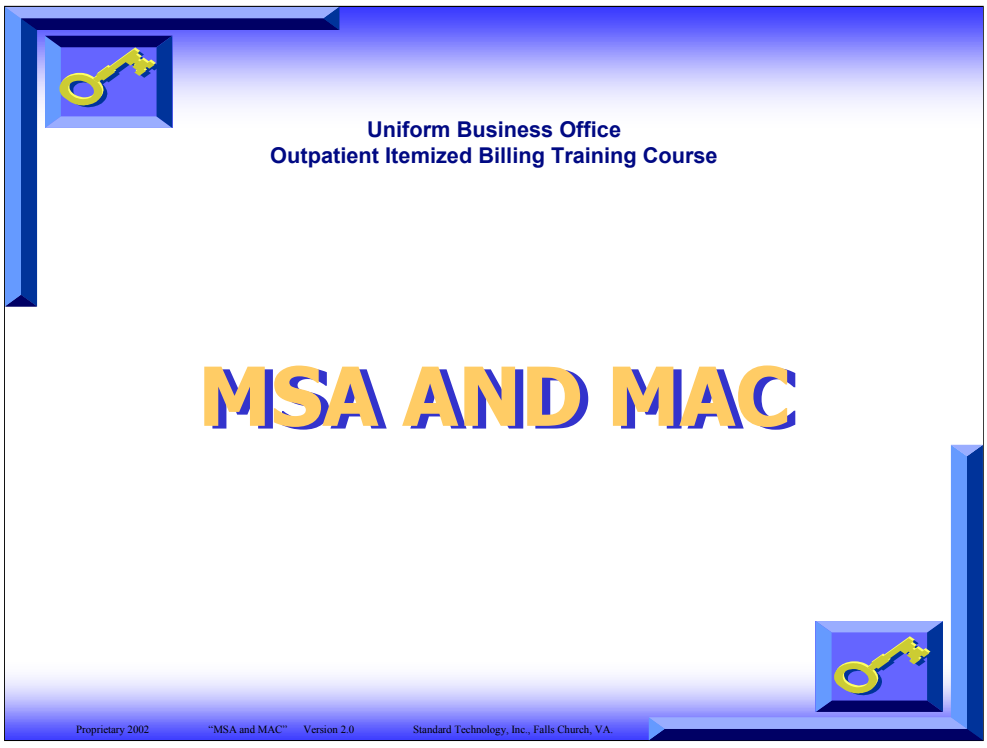
Gross Amount Due Submitted
DoD Format Requirements: **Required**
Enter total due. Equals sum of Usual & Customary Charge, Ingredient Cost Submitted, Dispensing Fee Submitted, Incentive Amount Submitted, and Other Amount Submitted.

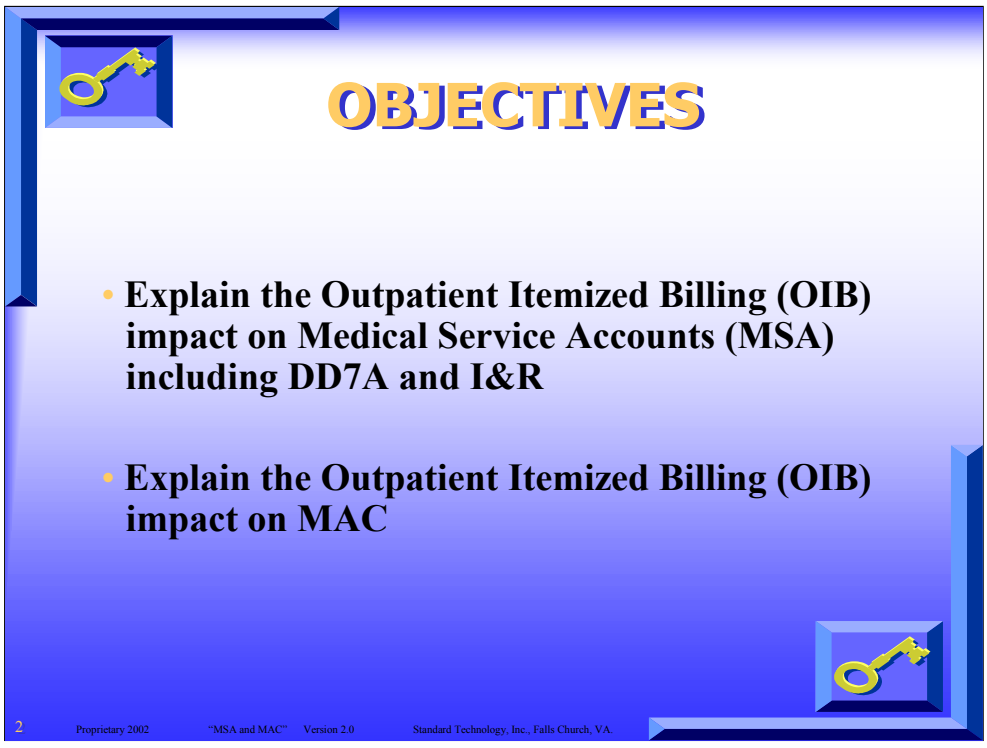
Patient Paid Amount
DoD Format Requirements: Conditional
Enter amount of cost paid by the patient. (**Default =0.00)**

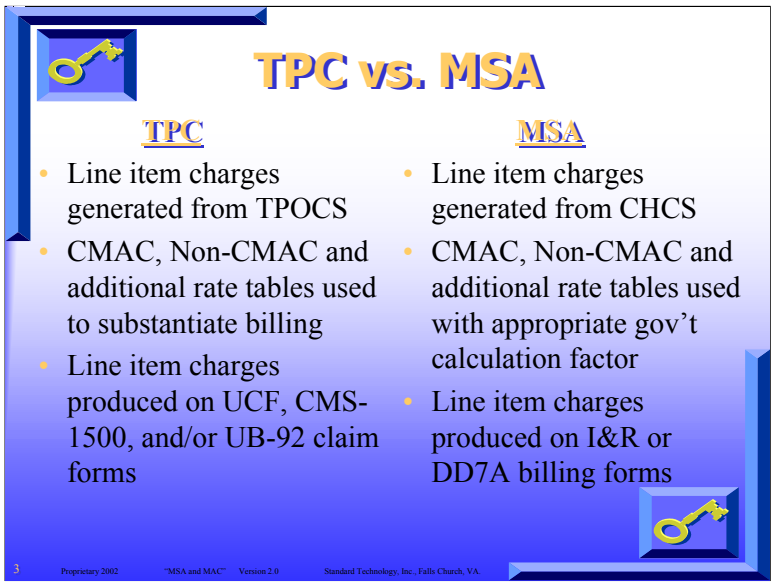
Other Payer Amount Paid
DoD Format Requirements: Conditional
Enter total paid by the other payer.

Net Amount Due
DoD Format Requirements: **Required**
Enter remaining balance due. Equals Gross amount due subtracted by sum of Patient Amount Paid and Other Payer Amount Paid.

Compound Prescriptions – Limit 1 compound prescription per claim
DoD Format Requirements: Not Required (Manual Process)
Enter COMPOUND RX in the Product Service ID area(s) and list each ingredient name, NDC, quantity, and cost in the area on the reverse side at the bottom of claim form. Use a separate claim form for each compound prescription.


Uniform Business Office
Outpatient Itemized Billing Training Course
MSA AND MAC
Proprietary 2002 "MSA and MAC" Version 2.0 Standard Technology, Inc., Falls Church, VA.


OBJECTIVES
• Explain the Outpatient Itemized Billing (OIB) impact on Medical Service Accounts (MSA) including DD7A and I&R
• Explain the Outpatient Itemized Billing (OIB) impact on MAC
2 Proprietary 2002 "MSA and MAC" Version 2.0 Standard Technology, Inc., Falls Church, VA.



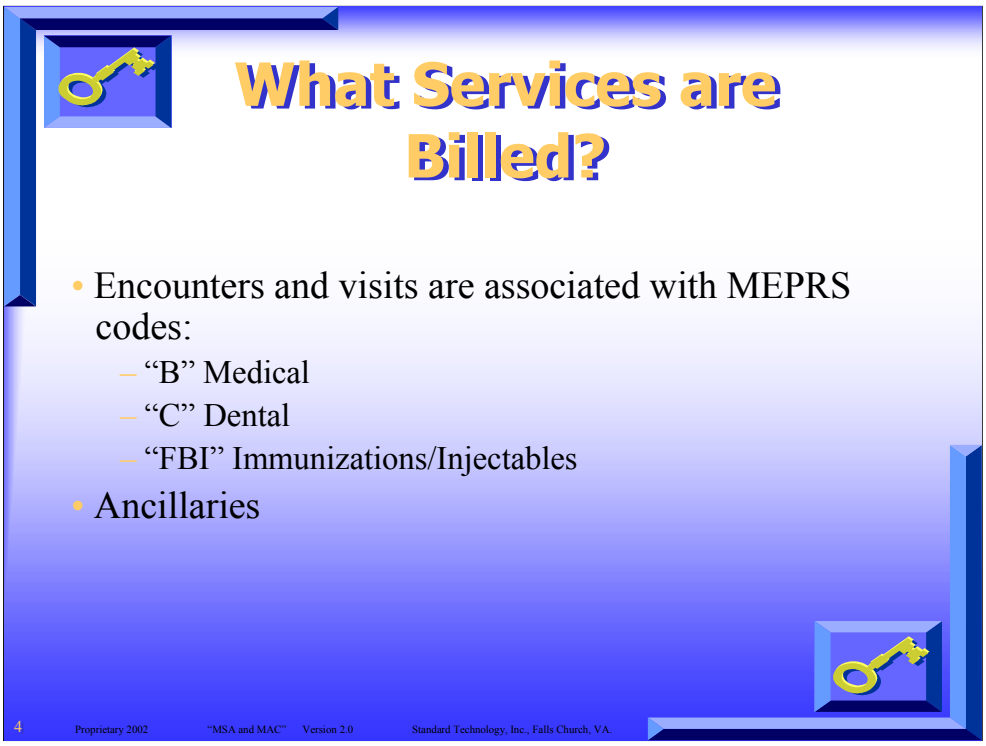
- MSA patient visits will be coded in ADM within CHCS, the same as TPC.
- The TMA is currently looking to move toward using the CMS-1500 and the UB-92 to bill for MSA.

- MSA will use the same rate tables as TPC but will also include the Government Calculation Factor (percentage discount) which is used to calculate discounted charges related to the Inter-Agency Rate (IAR) and International Military Education and Training (IMET) sales codes.

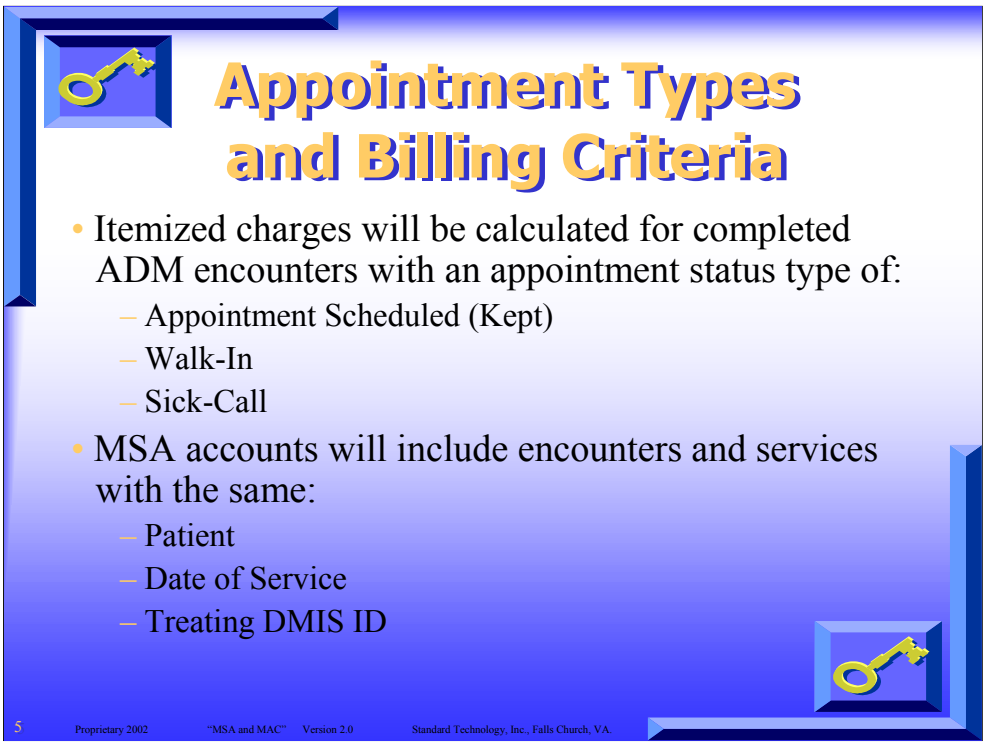
- Patient requests or necessary work-arounds may necessitate the use of the UCF, CMS-1500, or UB-92 the claim forms.
  - These claim forms can be forwarded directly to the payer resulting in faster turn-around time.
  - Statistically, patients settle their charges within 30-90 days.
  - MSA user will have to produce claim forms using a manual process.

- Patients cannot be given a claim form as a bill for services; they must be presented with an I&R.
  - With the line item detail on the I&R, patients will be able to accurately file their claims and receive better reimbursement.

- It is important to remember that if a claim is filed on behalf of the patient any unpaid balances by the payer will be the responsibility of the patient.
  - Under the concept of itemized billing, patients will no longer be required to pay for visits in advance of treatment, except in the cases of elective surgery.
  - The UBO Manual will be updated to allow delayed payment of services for at least 30 days.
  - A copy of the UBO Manual can be obtained from the UBO website, which also lists best practice ideas, such as a the Credit Card Implementation Program. Please reference your references handout for the address to the website.

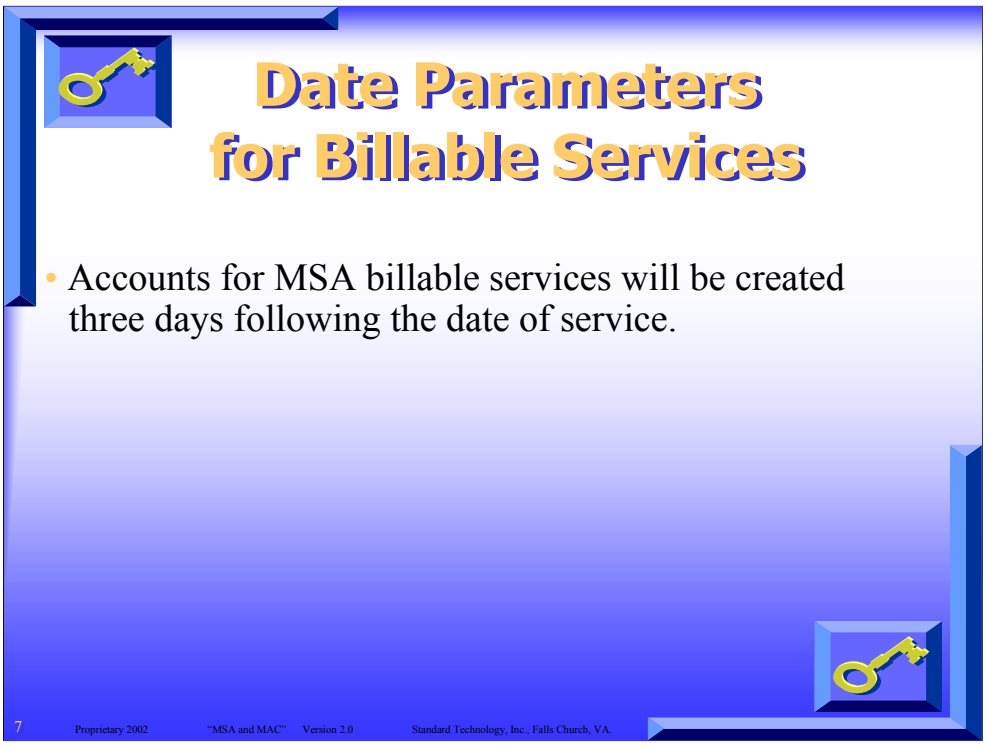


- Dental services will be automatically billed on the I&R if they are captured in CHCS.



- Only visits with the same date of service and treating DMIS ID will be included on a MSA account, regardless of whether the service has been linked to an encounter by the provider.
- MSA users will be able to manually add laboratory and/or radiology procedures if not captured by CHCS by entering the:
  - Lab Accession Number
  - Radiology Exam Number
- Pharmacy charges may be added by entering the Prescription Number and the calculated charges.
- DME/DMS can also be added based on the HCPCS Level II and the appropriate modifier, if applicable.

- These Service Categories indicate either what type of service was rendered or where the service took place.
- The NDC and procedure codes used will determine the associated charges.
- The One-Time-Charges option may be used to manually create an account for back-billing purposes or for services requiring pre-payment such as Cosmetic Surgery.

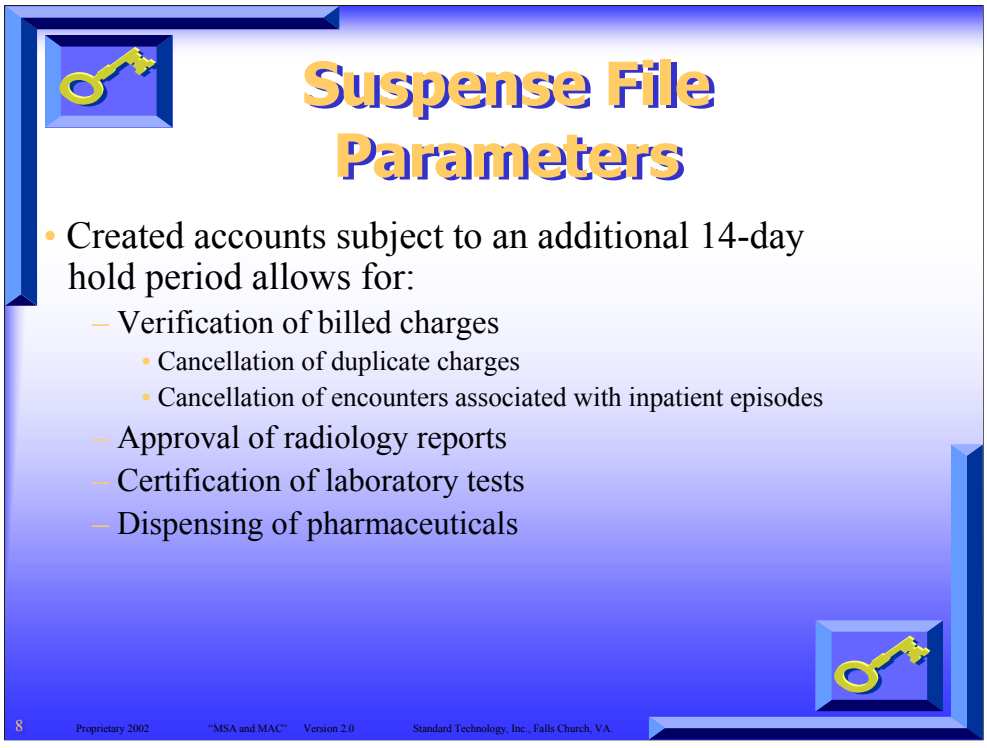


- Outpatient encounters can only be billed after the encounter coding is complete, indicating that it has passed all Standard Ambulatory Data Record (SADR) edits.
  - One important requirement will be that the encounter has at least one ICD-9-CM diagnosis code and one CPT code.
  - Any lab and rad service must contain a CPT code that is active in the CHCS rate table for that date of service.
  - Any pharmacy medications issued must contain a NDC code that is active in the CHCS pharmacy table for that date of service.
  - If coding does not pass SADR edits, it will appear on the OIB Suspense File Exception Report, which will be discussed later in the presentation.

- Lab tests can only be billed after the test result has been certified.

- Because billed charges are based on the Patient Billing Category (PATCAT) on file at the time the services were rendered, any changes made to the PATCAT after the date of service will require the user to process the bill manually.

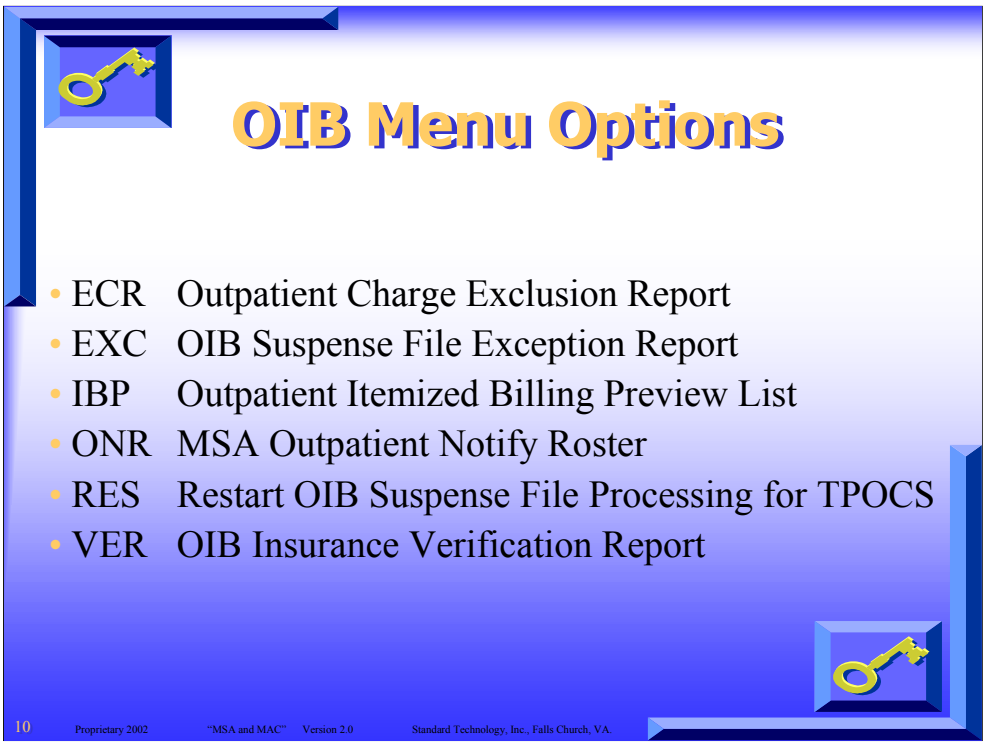
- The date of service is also used to determine the applicable Fiscal Year of the MSA Accounts Receivable.



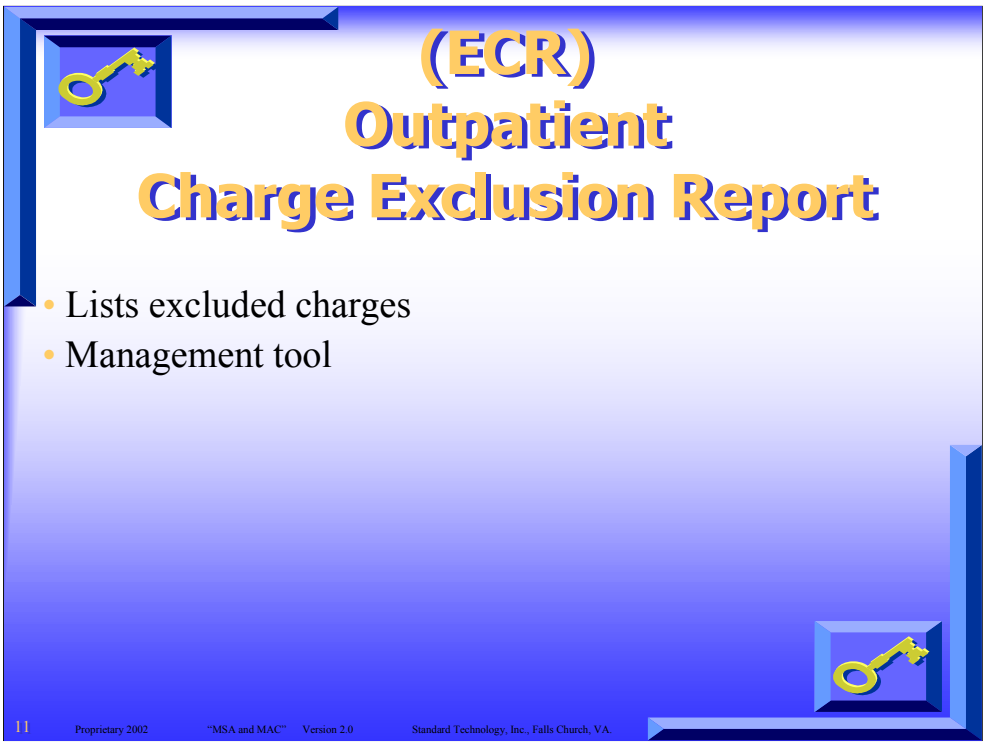
- Once an account is created, after the three day hold, it is transferred into a suspense file for 14-days with a status of "P" for Pending.
- While in Pending status line item charges may be appended or excluded by the user.
- The 14-day pharmacy hold period is to allow for the possibility that a prescription is "Returned to Stock" and should not be billed.

New MSA Menu

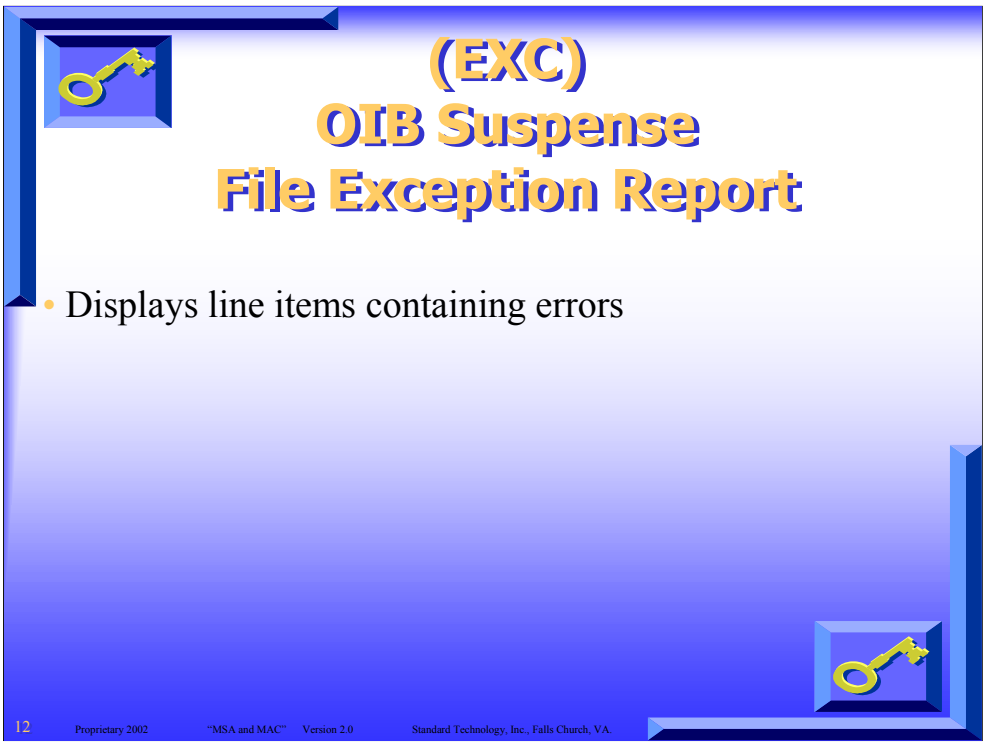
- CFM Cashier Functions Menu
  - OPE Outpatient Accounts Edit
  - CLK Cashier Action Screen
- OFM Office Functions Menu
- MSR Cashier/MSA Reports Menu
- D7A DD7A Billing Menu
- MRM Monthly Reports Menu
- NPM Nightly Processing Menu
- RSM Reprint Reports Menu
- OIB Outpatient Itemized Billing Menu



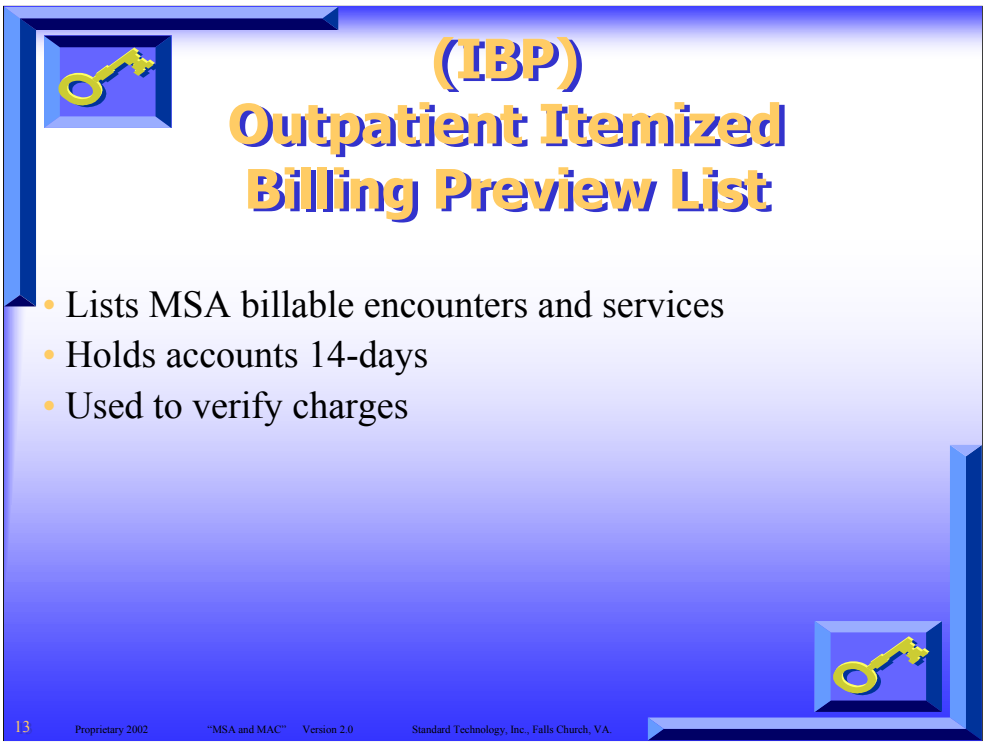
- The last two menu options listed pertain to TPOCS and will not be used in MSA processing.



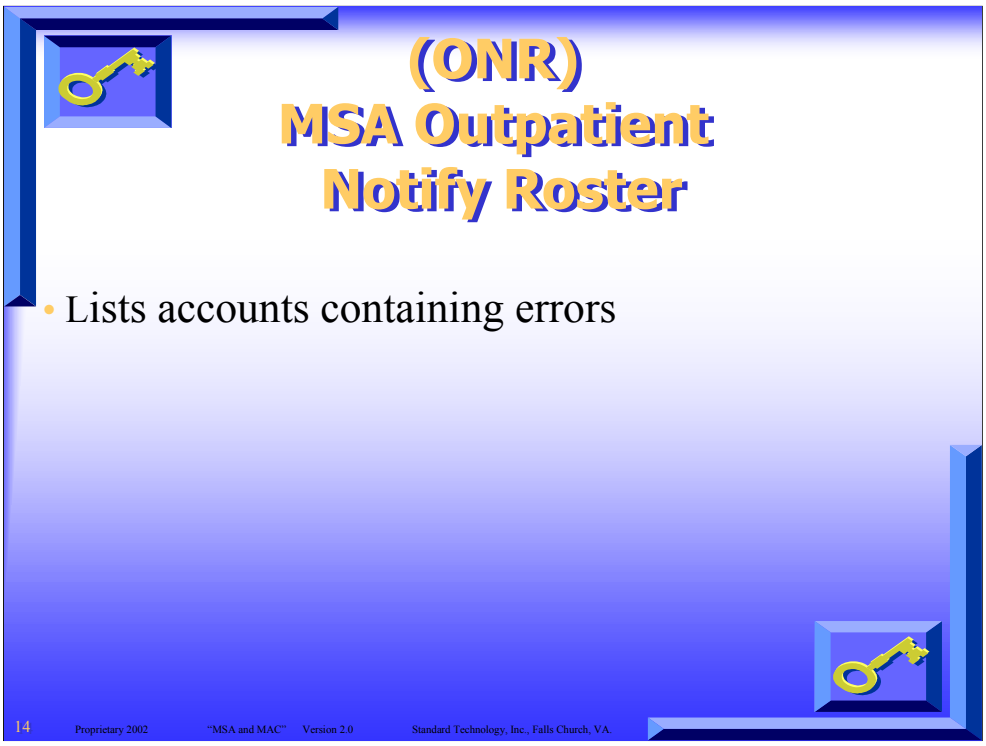
- The Outpatient Charge Exclusion Report:
  - Lists charges that have been excluded for various MTF defined reasons.
  - May be printed for either DD7A or I&R accounts to support accountability. This a good report for program managers to audit user patterns.



- The OIB Suspense File Exception Report:
  - Displays line items not included during the processing of the OIB suspense file for various reasons.



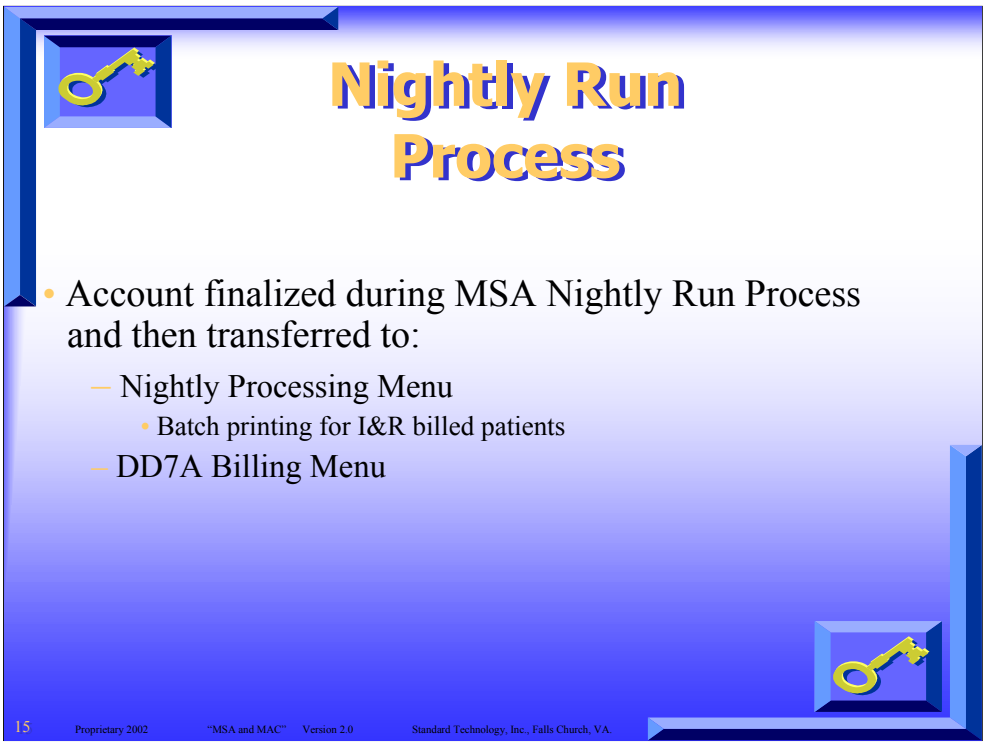
- The Outpatient Itemized Billing Preview List:
  - Lists patients that are MSA billable with charges that are Pending (suspense file).
  - Is used to verify charges:
    - User can change account status from "P" to "B."
    - MSA Accounts in "B" status will be removed from the Preview List, unless updated charges have been added to the account.



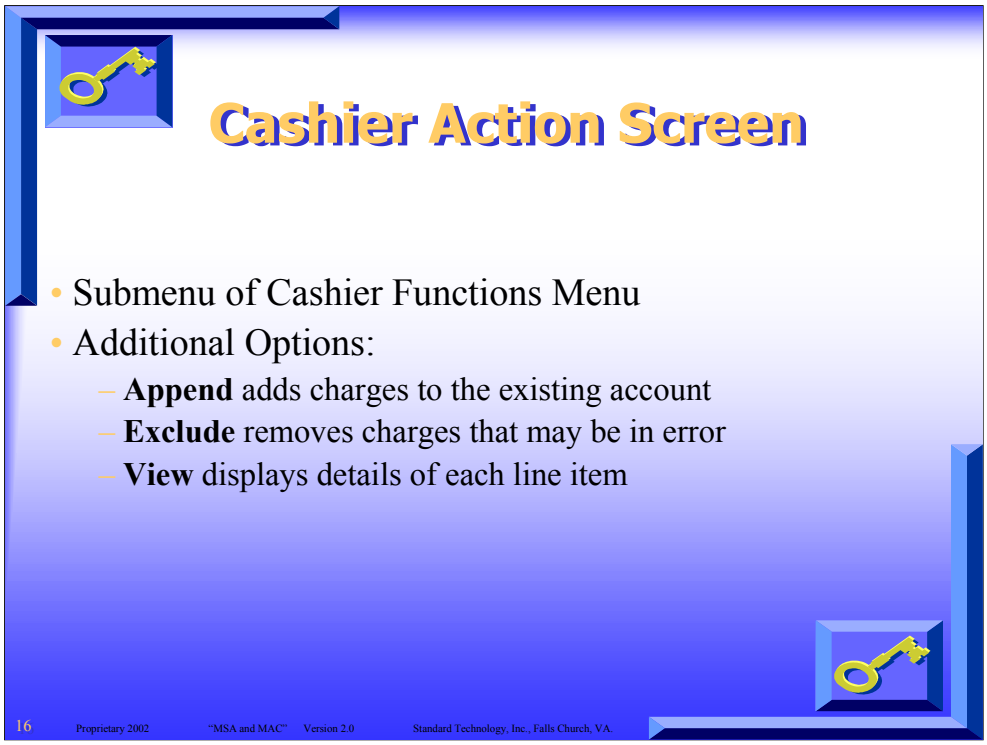
- The MSA Outpatient Notify Roster lists accounts with various notify messages which identify situations where charges need to be validated or could not be calculated.

- Notify messages include:

  – CMAC Locality Rate Table Not Found
  – Inactive NDC Code - Rate Not Calculated
  – Additional Services Added To Account - Review Required
  – Encounter Completion Pending



- After the hold period, the account is finalized during the MSA Nightly Run and then transferred to the print queue for batch printing.
- Status of account will be changed from "P" Pending status to "O" Open status. At this point, the account is added to the Accounts Receivable.
- At any time during the 14-day hold, the user can manually change status from "P" to "B" Bill status but account will not print until hold period is expired.
  - "B" status indicates to the user or any other user that this account has been verified and is ready to print.

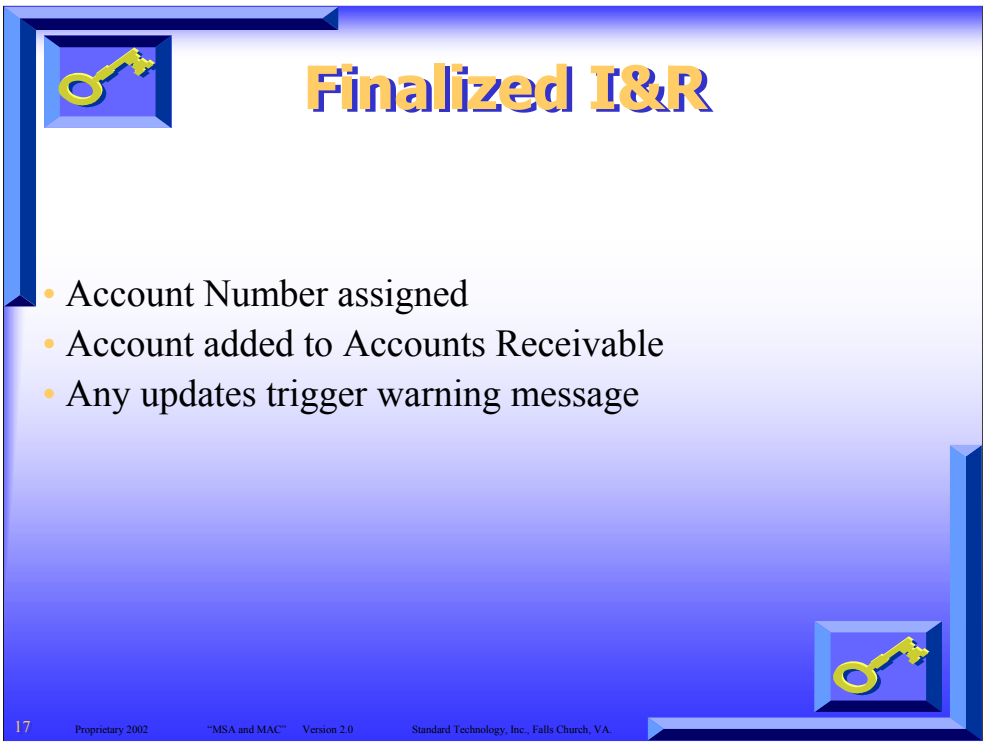


- The Cashier Action Screen has additional options:

  – **Append** provides the ability to manually add charges to the existing account for the same patient, treating DMIS ID and Date of Service if it is within the 14-day hold period.

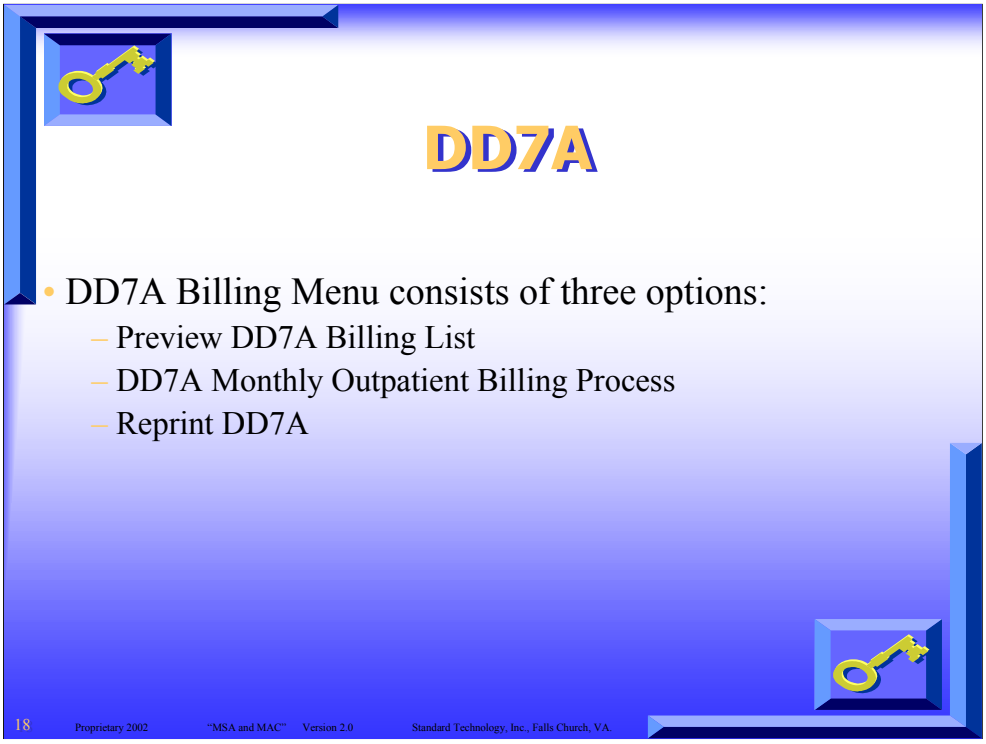
  – **Exclude** provides the ability to remove charges that may be in error:
    - If excluded, the sales code will change to "NC" for No Charge and the quantity and charges to zero.
    - The user will have the option to enter a Reason Code for the excluded charge. These codes will be site definable.

  – **View** allows the user to see the details for each line item charge such as provider, CPT code and rate.



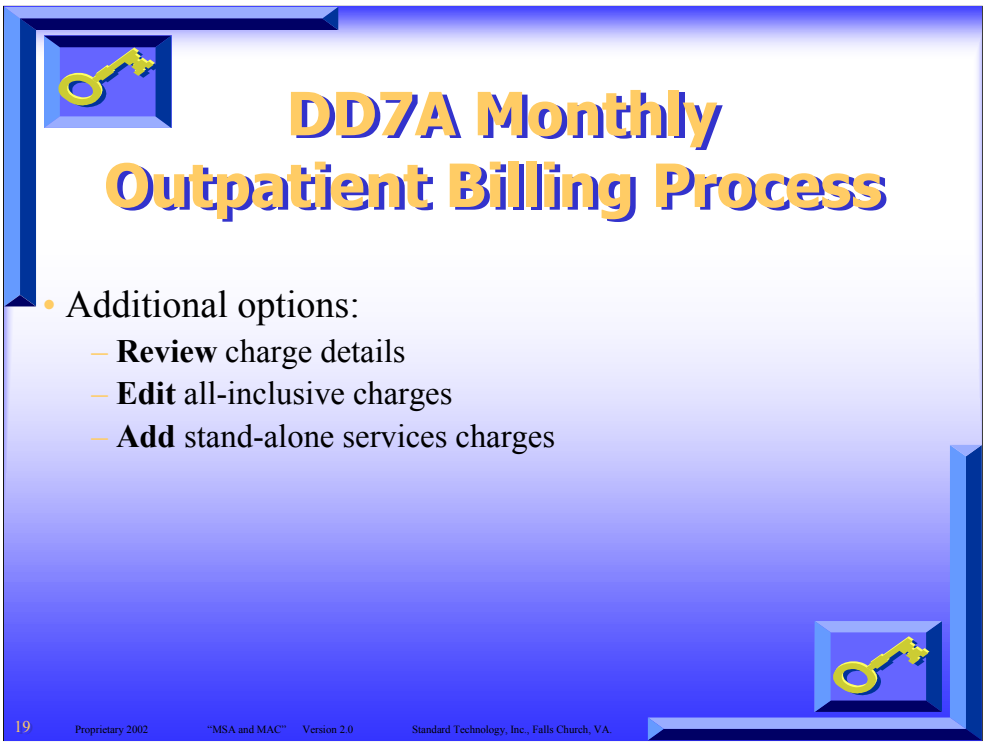
- If updated charges are identified for an MSA account with a finalized I&R, a warning or notify message will be produced indicating possible additional processing or recalculation is necessary.
- An interim I&R can be printed at any time during the14-day hold which will state that the charges are pending and a final statement of charges are to follow.

Please look in the back of this presentation to find the Finalized I&R handout as we proceed.

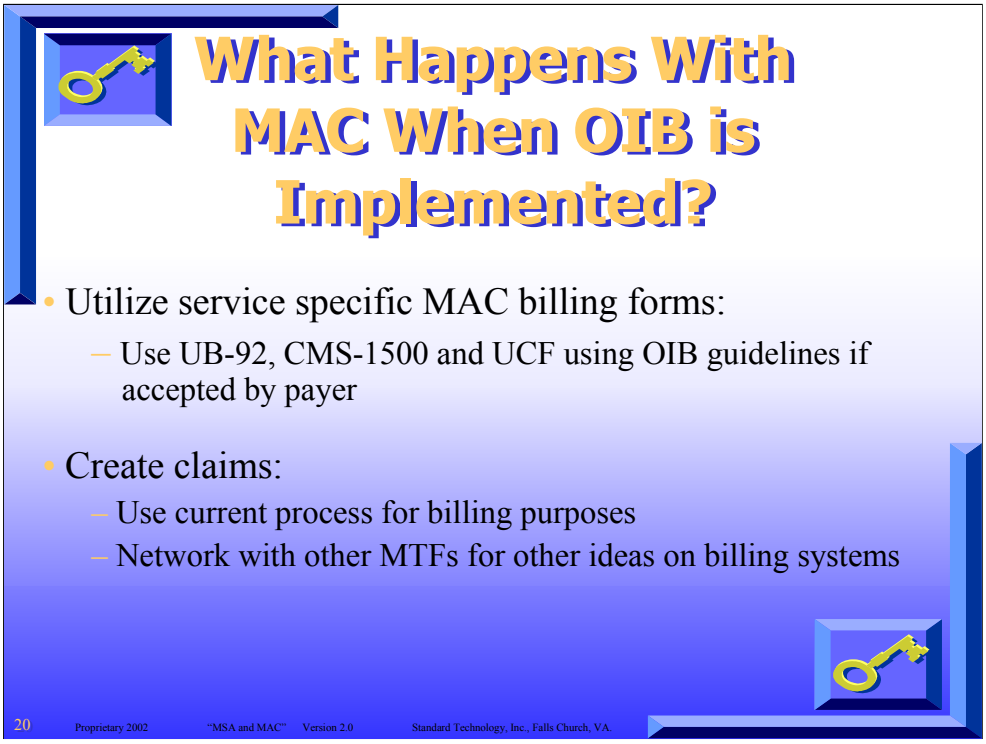


- The DD7A Billing Menu Option is the main menu for the DD7A functionality.
- The Billing Table Enter/Edit and the Billing Table Report options have been removed for this new CHCS version.
- We will discuss the functions of DD7A that are exclusive to this form's billing process.
- Unchanged functions from the previous version of CHCS or ones that are performed in the same manner as the I&R billing function will not be discussed in detail.
- The DD7A Outpatient Preview Billing List provides a list of patients that are DD7A billable with charges that are pending review and selection for inclusion on the monthly DD7A Report.

Please look in the back of this presentation to find the DD7A handout as we proceed.



- DD7A Monthly Outpatient Billing Process permits user to:
  - **Review** the itemized billing charge details:
    - This option is where the user would append, exclude or print as well.
  - **Edit** charges for visits with dates of service prior to the OIB implementation date.
  - **Add** charges for stand-alone services that are not associated with an outpatient encounter such as Ambulance, Dental, DME/DMS and One-Time-Charges.
- DD7A can be printed as a summary report, a detailed report with total charges by patient, or a line item detailed report.
  - The line item detailed report should only be submitted to patient.



- The MAC program can continue using current processes on the Service forms.
- If the payer requests a UB-92, CMS-1500 or UCF there is a new MAC module in TPOCS that will allow for the generation of these forms.
- All data is manually entered in TPOCS using pre-established tables.
- The only required field is provider name.
- The appropriate billing form will have to be produced manually from the encounter information retrieved from CHCS/ADM.
- NDC and CPT/HCPCS codes will have to be mapped to its rate based on the DMIS-ID.
- There will be more work involved in gathering encounter/billing information.

Key Points

- The I&R and DD7A will include all billed charges for encounter related procedures, services and/or billable stand-alone ancillary services.
- DD7A can be printed itemized (detailed) at the users discretion
- MSA will no longer produce bills or collect payment for services prior to the patient receiving treatment.
- Itemized services will be obtained from CHCS/ADM and manually listed on Service specific MAC billing form.
- Verify billed charges prior to finalizing MSA invoice or monthly DD7A Report.
- Think compliance paramount for documentation and coding.


22
Proprietary 2002
"MSA and MAC"
Version 2.0
Standard Technology, Inc., Falls Church, VA.

Invoice & Receipt Example

NAVAL AMBULATORY CARE CEN GROTON 21 Jan 2002 1507 Page: 1
Personal Data - Privacy Act of 1974 (PL 93-579)

1 NAVAL AMBULATORY CARE CTR
BOX 600 CODE 0C
GROTON CT 06349-5600

2 DEPARTMENT OF THE NAVY
HOSPITAL INVOICE AND RECEIPT

SPONSOR NAME: FORBES,MSA CONGRESS 3 SERVICE: BRANCH OF SVC 4
DUTY ADDRESS: SENATE OFC BLDG 5 GRADE: 6
ROCKVILLE MD 20852

BILLING NAME: FORBES,MSA CONGRESS 7 FMP/SSN: 20/122-22-3333 8
BILL ADDRESS: 100 LUNA PK DRIVE
ALEXANDRIA VA 22305 9

PATIENT NAME: FORBES,MSA CONGRESS 10 ACCOUNT NO: A700848 11
VISIT DATE: 3 Jan 2002@0900 12,1 TOTAL CHARGES: $286.46 14

CHARGES

16a Svc	16b Code	16c Description	16d Qty	16e Svc Date	16f Sales	16g Charges
OPE	99285	EMERGENCY DEPT VISIT	1	03 Jan 2002	FOR	168.27
LAB	82565-00	ASSAY OF CREATININE	1	03 Jan 2002	FOR	9.09
LAB	80051-00	ELECTROLYTE PANEL	1	03 Jan 2002	FOR	13.49
RAD	74002-TC	X-RAY EXAM SERIES, ABDOMEN	1	03 Jan 2002	FOR	19.40
RAD	74002-26	X-RAY EXAM SERIES, ABDOMEN	1	03 Jan 2002	FOR	33.61
PHR	G643545	CIPRO	20	03 Jan 2002	FOR	42.60

INVOICES & RECEIPTS

DATE	PAYMENT	TYPE PAY	CHECK NO.	CTRL NO.	BALANCE
22 Jan 2002	0.00			02-241	286.46
17	18	19	20	21	22

1. Payment of this bill is due upon receipt. You may inspect and copy government records related to this debt to the United States and question its validity or accuracy. If payment is not received for this debt within 30 days of hospital discharge or outpatient date of service, your account is subject to referral to higher authority for collection action, involuntary pay checkage (if you or your spouse is a federal employee), and referral to your employer.

2. Per the Debt Collection Act of 1982, interest and/or administrative charges will be assessed on accounts not paid within 30 days of initial billing. If payment in full is not possible at this time, installment payment arrangements may be made by contacting the COLLECTION AGENT at 860-694-2577.

3. Please make checks payable to: NAVAL AMBULATORY CARE CENTER
and mail to: COLLECTION AGENT
BOX 600 CODE 0C

GROTON CT 06349-5600

Prepared by: _____ Received by: _____

AF FORM 1127/DA FORM 3154/NAVMED FORM 7270/1 (CG-CHCS/SAIC)

Invoice & Receipt (I&R) Descriptions

Item	Label	DoD Required	Description
Items 1-2 Facility Information (Blue)			
1	Provider Name, Address	X	Name of Medical Activity, base and/or post, and Major Command as applicable providing medical care in continental United States. Name of Medical Activity, APO/FPO and Major Command outside continental United States
2	Organization	X	Military branch
Items 3-9 Sponsor and Billing Information (Green)			
3	Sponsor Name	X	Name of the patient's sponsor (Last, First)
4	Service	X	Service code
5	Duty Address	X	Duty address of sponsor
6	Grade	X	Military grade or status of the individual (e.g. civilian, eligible family member, etc.)
7	Billing Name	X	Name of person to be billed (Last, First)
8	Fmp/Ssn	X	FMP and SSN of person to be billed
9	Billing Address	X	Address of person to be billed
Items 10-22 Patient, Episode and Accounting Information (Orange)			
10	Patient Name	X	Name of patient. (Last, First)
11	Account/Register Number	X	Account or register number of visit/admission
12	Adm Date (Inpatient) or Visit Date (Outpatient)	X	Date of admission or visit DD MMM YYYY
13	Disch Date (Inpatient)	X, if app.	Date of discharge, if applicable DD MMM YYYY
14	Total Charges	X	Total charges calculated from sum of Inpatient Charge (Item 15f) or sum of Outpatient Charges (Item 16g)
15a	Beg Date (Inpatient)	X, if app.	Beginning date of service DD MMM YYYY
15b	End Date (Inpatient)	X, if app.	Ending date of service DD MMM YYYY
15c	Chg Days (Inpatient)	X, if app.	Number of charged days
15d	Nchg Days (Inpatient)	X, if app.	Number of uncharged days
15e	Rate (Inpatient)	X, if app.	Charge rate for the service
15f	Charge (Inpatient)	X, if app.	Calculate total charge for service by multiplying Rate (Item 15e) by Charged days (Item 15c)
16a	Svc	X	Three-character Service Category description
16b	Code	X	CPT/HCPCS code, Radiology Number, Laboratory Accession Number, or Prescription Number
16c	Description	X	Description of service
16d	Qty	X	Quantity of services
16e	Svc Date	X	Date for service DD MMM YYYY
16f	Sales	X	Sales Category
16g	Charges	X	Charge for service
17	Date	X	Date of calculated charges DD MMM YYYY
18	Payment	X	Amount of payment received
19	Type Pay	X	Form of payment
20	Check No.	X	Check number if applicable

Invoice & Receipt (I&R) Descriptions

21	Ctrl No.	X	Control number of I&R
22	Balance	X	Balance calculated by subtracting Payment (Item 18) from Total Charges (Item 14)

DD7A Example

REPORT OF TREATMENT FURNISHED PAY PATIENTS
OUTPATIENT TREATMENT FURNISHED (PART B)

REPORT CONTROL SYMBOL

1. INSTALLATION PROVIDING TREATMENT *(Name and address)*

2. MONTH AND YEAR COVERED BY THIS REPORT

3. CATEGORY OF PATIENTS

4. AUTHORITY FOR ADMISSION

NAME *(Last, first, middle initial)* AND SSN 5	MILITARY GRADE 6	ORGANIZATION 7	DIAGNOSIS 8	TREATMENT	
				DATES 9	NUMBER 10

11. DATE

12. AUTHORIZATION *(Signatures, military grade, organization of Commanding Officer)*

13. TOTAL

DD Form 7A, Aug 76

DD7A Instructions

- The DD7A will be used to bill outpatient medical charges for patients of Federal Agencies and/or Foreign government based on the DD7A Pay Mode within the Patient Billing Category Table.
- All charges are calculated as line item charges, but will be summarized per patient and date of service on the monthly DD7A billing report.
- There will be a system option for printing an itemized DD7A form per patient.
- An Outpatient Inter-Agency (IOR) and International Military Education and Training (IMO) calculation factor will be applied to total charges on the DD7A, except for Dental Services, which are calculated per specified rate for IOR, IMO and Full Rate billing.

DD7A CHCS Automated Example

Bill No: 0121 - 02 - FEB

Report of Treatment Furnished Pay Patients
Hospitalization Furnished (Part B) Outpatient Services

Prepared on: 07 Mar 2002 Printed on: 07 Mar 2002 Page: 1 of 1

MSA OIB HOSPITAL
MSA OFF ADDR
MSA OFF CTY-ST-ZIP

Patient Charge Category: NOAA ACTIVE DUTY, B11
Country of Origin: UNITED STATES

Patient Name / FMP/SSN	Pat Cat / Grade	Service Date	MEPRS / Clinic/Services	Amount Billed
Division: BRANCH MEDICAL CLINIC				
BAILEY,JONATHAN 20/NNN-NN-N182	B11 O5	18 Feb 02	BHAK PHYS EXAM NF (OPE+)	151.23
BAILEY,JONATHAN 20/NNN-NN-N182	B11 O5	28 Feb 02	BBDK OPHTHAL CLINIC NF (OPE)	181.87
Division: INPATIENT MTF				
BLAKE,WADE J 20/NNN-NN-N714	B11 O4	26 Feb 02	BFAG PSYCHIA ADUL BE (OPE)	230.94
CHRISTMAN,EMILY B 20/NNN-NN-N235	B11 O5	23 Feb 02	BCCA OBSTETRIC CL BE (OPE)	144.62
DAVIS,ERIC S 20/NNN-NN-N234	B11 E5	19 Feb 02	BBIA UROLOGY CL BE (OPE+)	228.45
FINN,MICHELE A 20/NNN-NN-N732	B11 O4	20 Feb 02	FCCA CHAMPUS SUPPORT (PHR)	242.14

NOAA ACTIVE DUTY Billing This Period: 1179.25

*Adjustments This Period: 0.00

Adjustments Billing This Period: 1179.25

NOAA ACTIVE DUTY Billing Year to Date: 246,667.83

Date: 5 Mar 2002 Certified and Authenticated by _____

Uniform Business Office
Outpatient Itemized Billing Training Course

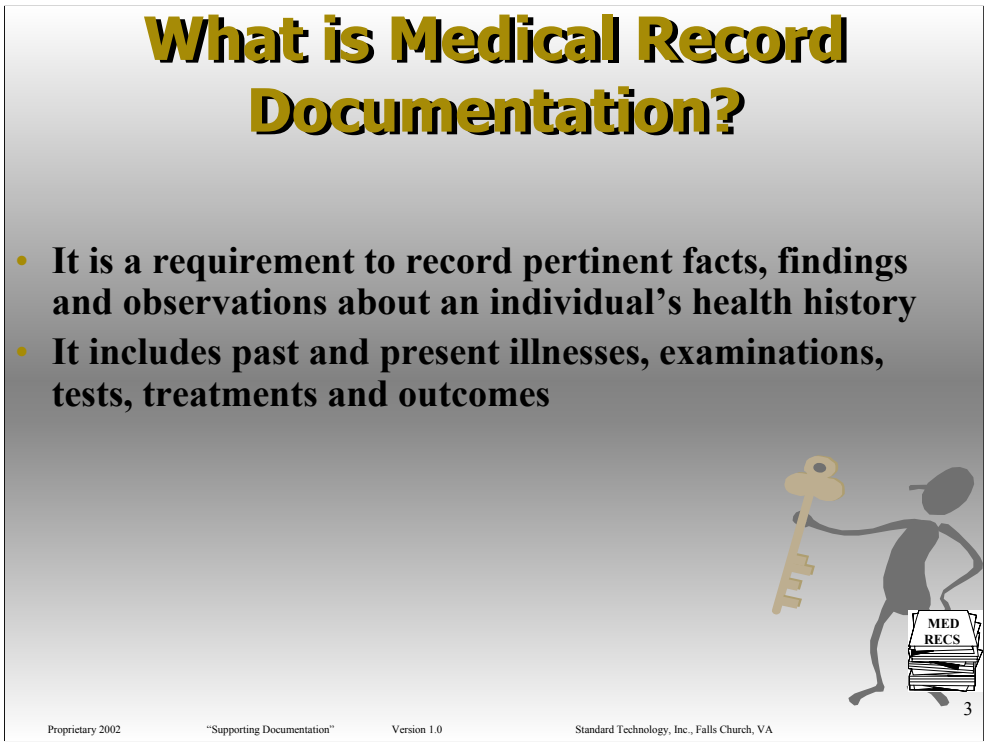
Supporting Documentation and Coding for Accurate Billing

Proprietary 2002 "Supporting Documentation" Version 1.0 Standard Technology, Inc., Falls Church, VA

Objectives

- Discuss medical record documentation
- Discuss the results of valid data as well as poor documentation
- Explain how proper documentation relates to coding and billing

Proprietary 2002 "Supporting Documentation" Version 1.0 Standard Technology, Inc., Falls Church, VA



Medical Record Documentation must be:

• Comprehensive

• "All encompassing"
- documentation may include the clinicians' subjective observations, objective clinical finding, assessments and plans
- the civilian sector practices many formats of documentation
- key is to include all factors which relate to the care of the patient and impacts coding (e.g. external information which contributed to an injury such as falling as a result of tripping over furniture.)

Medical Record Documentation must be:

- Timely- it is an "ongoing story" of the patient's health status
- It contributes to a high level of quality care by concisely and clearly illustrating course of action taken by provider (s) and rationale for his or her treatment.
- Coding and billing are based on what is documented/supported in the medical record:
  - evaluation and management
  - diagnoses
  - procedures and ancillary services

Supporting Documentation

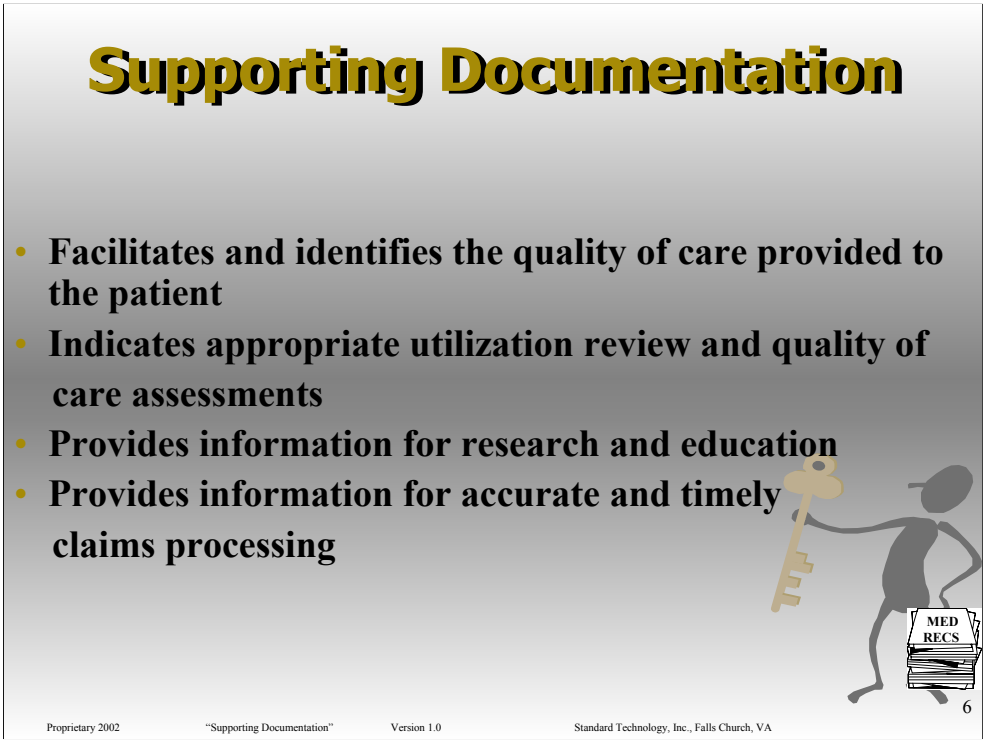
Elements of good documentation:

- **Should be complete and legible**
- **Supports medical and surgical care, services, treatment, diagnoses and procedures coded from the medical record**
- **Provides accessibility of past and present medical conditions to treating and/or consulting physician**
  - Ensures continuity of care

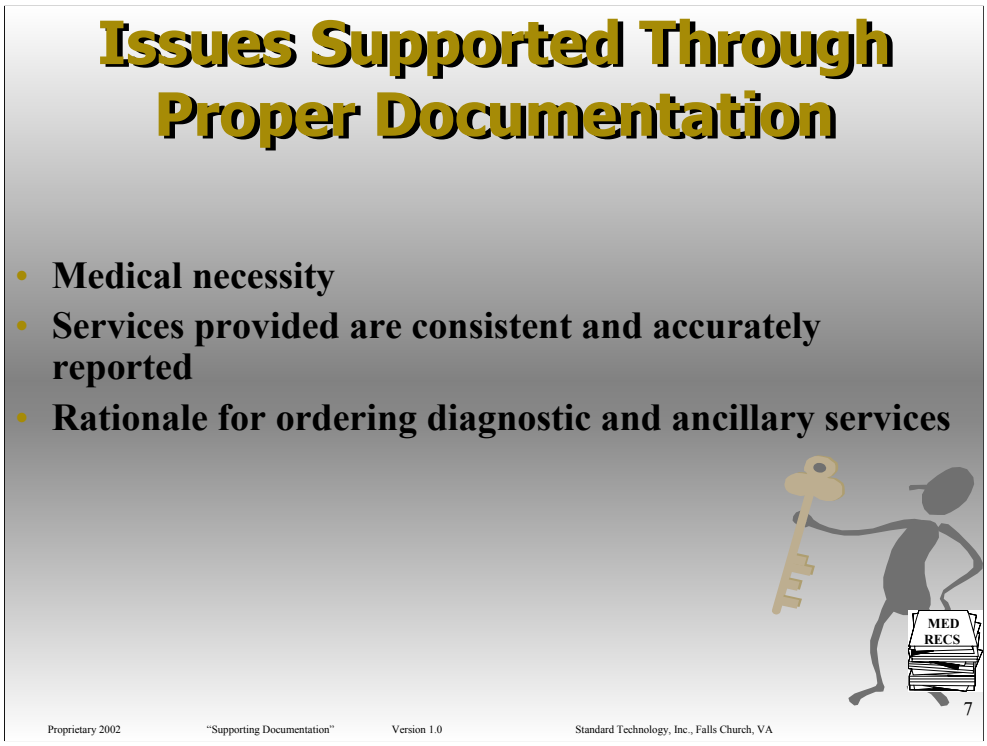
- "If it was not documented in the medical record it was not done". This is a **cardinal rule** regarding documentation.

- As it relates to coding (which billing is based upon): what is documented in the medical chart supports what is coded in that record and what is ultimately billed for (e.g. use of assistant surgeon or multiple procedures performed on the same day)

- Supporting documentation provides for continuity of care for specialists as well as transfer of care to another physician.



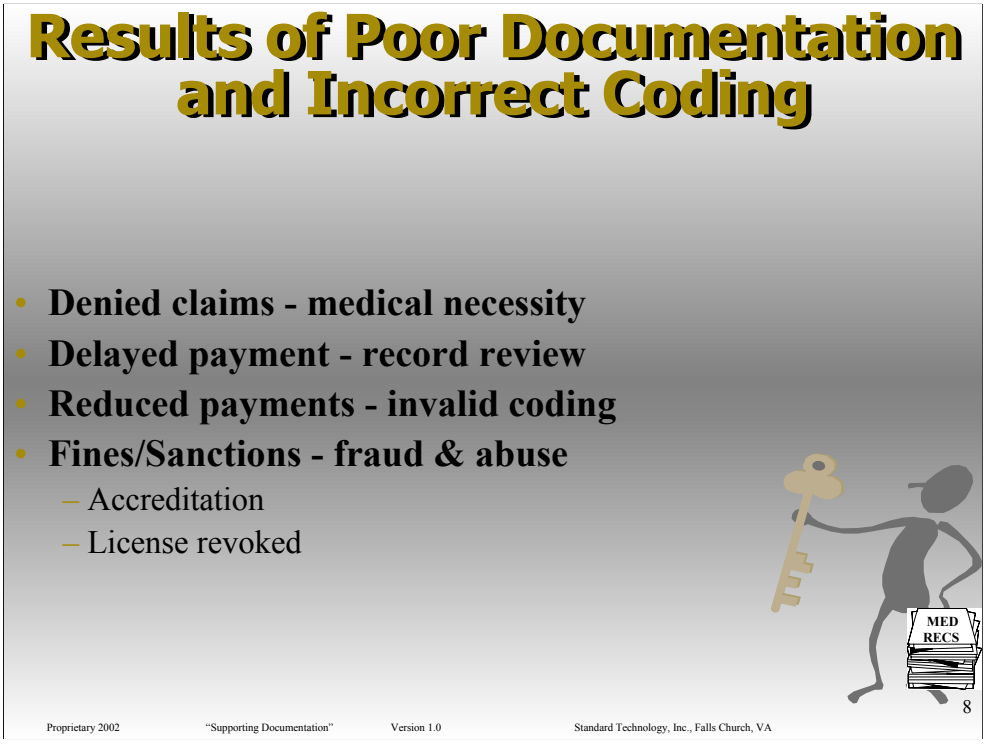
- It facilitates the ability of the provider to evaluate and plan the patient's immediate treatment and monitor the patient's health over time.
- It allows communication among providers involved in the patient's care.
- The Clinical Pertinence Review process of the medical record can be conducted to ensure all required information is documented.
- Data can be collected and research done to enhance clinical technology.
- Data for "clean" claims will be provided.



Medical necessity example: Procedure for plastic surgery for facial burn **versus** cosmetic surgery for a face lift.

• Review the claims before sending them to the payer.

• Examples are:
  - Underutilization - whether or not enough tests were done to diagnose and determine the patient's problem and/or condition
  - Overutilization - unnecessary tests were done before determining the patient's problem and/or condition



- Neither the documentation nor the CPT-4 code support the care rendered to the patient. (BILLER OR CODER CANNOT ADD DOCUMENTATION TO THE RECORD)

- Payment is withheld until documentation regarding the specific question is reviewed, which may result in additional time taken from other responsibilities.

- For example, if up-coding is in question due to a lack of supporting documentation, the payment may be reduced (e.g. facility can get penalized on up-coding, which is the use of an inappropriate CPT-4 code/modifier.) While the CPT-4 code may describe the basic procedure performed, the use of an inappropriate modifier (such as multiple procedures when it is single) can result in lower payment.

- If the behavior is considered a consistent practice, then fines and sanctions may be incurred.

.

Valid Data Contained in Your Billing System Will Result in:

- Production of "clean" claims
- Faster turn-around time
- Reduction of paperwork
- Fewer mistakes
- Improve monitoring of resources
- Enhance workload distribution

Proprietary 2002 "Supporting Documentation" Version 1.0 Standard Technology, Inc., Falls Church, VA

How Proper Documentation and Coding Relate To Accurate Billing

(Proper Documentation) + (Accurate Coding) + (Prompt Billing) =

Optimization of Reimbursement which results in Increased Revenue

- Increased revenue can pave the way to enhancing patient care by:
  - recruitment and retention of staff
  - procurement of "state of the art" equipment
  - supporting longevity of MTF as a resource

Key Points

- **The responsibility of the trainer is to:**
  - **Share the importance and benefits of good supporting documentation with the team**
  - **Work collaboratively with the coder and other team members in follow up claim situations and to foster good documentation**

Proprietary 2002 "Supporting Documentation" Version 1.0 Standard Technology, Inc., Falls Church, VA

NOTE: Have participants turn to the "Supporting Documentation" quiz. Allow about 3-4 minutes to complete. Go over correct answers.

NOTE: A vital part of any workplace is a job aid—reminders to help busy workers remember important and key information.

Read "Supporting Documentation Job Aid Checklist Activity" to groups & allow 10 minutes for groups to create this checklist. Remind groups to appoint a secretary to record a master checklist to be presented to the entire group.

SUPPORTING DOCUMENTATION JOB AID/CHECKLIST ACTIVITY

As a group, create a checklist that identifies 10 important elements constituting good documentation. The checklist would be posted in the work area as an important job aid reference

Examples are:

- Legibility
- Patient signs/symptoms
- Physician/provider signature and date
- All treatments documented
- Correct spelling/abbreviations
- Use of standard medical abbreviations
- Use of credentials
- Use of lot numbers when administering vaccinations
- Use of modifiers

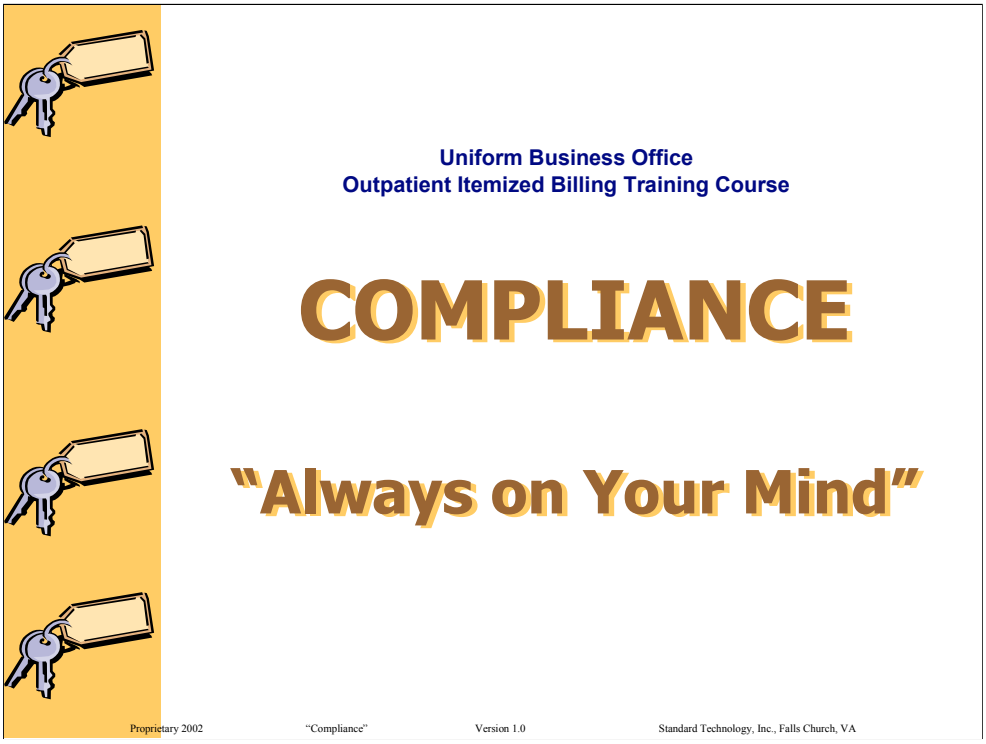
Supporting Documentation and Coding for Accurate Billing Quiz

For each of the numbered items, write the appropriate identifying letter in the answer column provided on the right. Choose the correct letter from the responses provided below the grid.

Item	Answer
1. Medical record documentation must be…	c
2. What is the formula for optimizing reimbursement?	e
3. Coding and subsequent billing are based on…	d
4. What is the "cardinal rule" of documentation?	g
5. It is NOT the role of the biller to…	f
6. Valid data contained in the billing system can result in…	a

Responses

(a) Faster turn around time, reduction of paperwork
(b) Denied claims
(c) Comprehensive/Timely
(d) Information documented/supported in the medical record
(e) Proper Documentation + Accurate Coding + Prompt Billing =
(f) Add documentation to the medical record
(g) "If it was not documented in the medical record it was not done."



Compliance is always on our minds both personally and professionally and it is expected in our society.

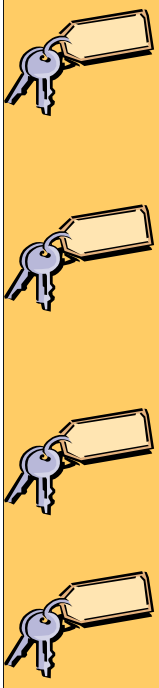
- For instance, parking in a handicapped spot just to run a quick errand and we worry What If…the police recognizes our car illegally parked or a physically challenged person needs to park in that spot and complains.

or

- Someone makes changes to entries on claims when he/she is not permitted to do so. Example, the date is altered or a patient's status is changed. For a while he/she worries if it is the correct thing to do, but continues to do so, because the practice has not been discovered and or corrected.

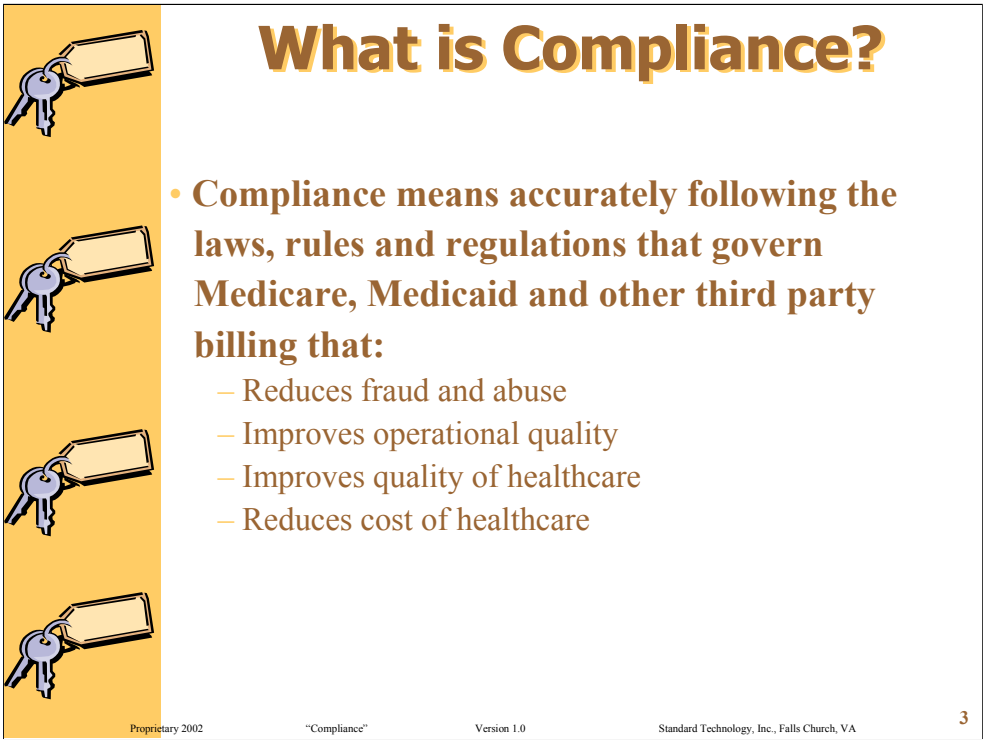
Note: That type of behavior is known as fraud and abuse because the individual is not compliant with the law.

Note to Trainer: Have class refer to Compliance Audit Tool and UBO Compliance Plan attached at the end of this presentation.

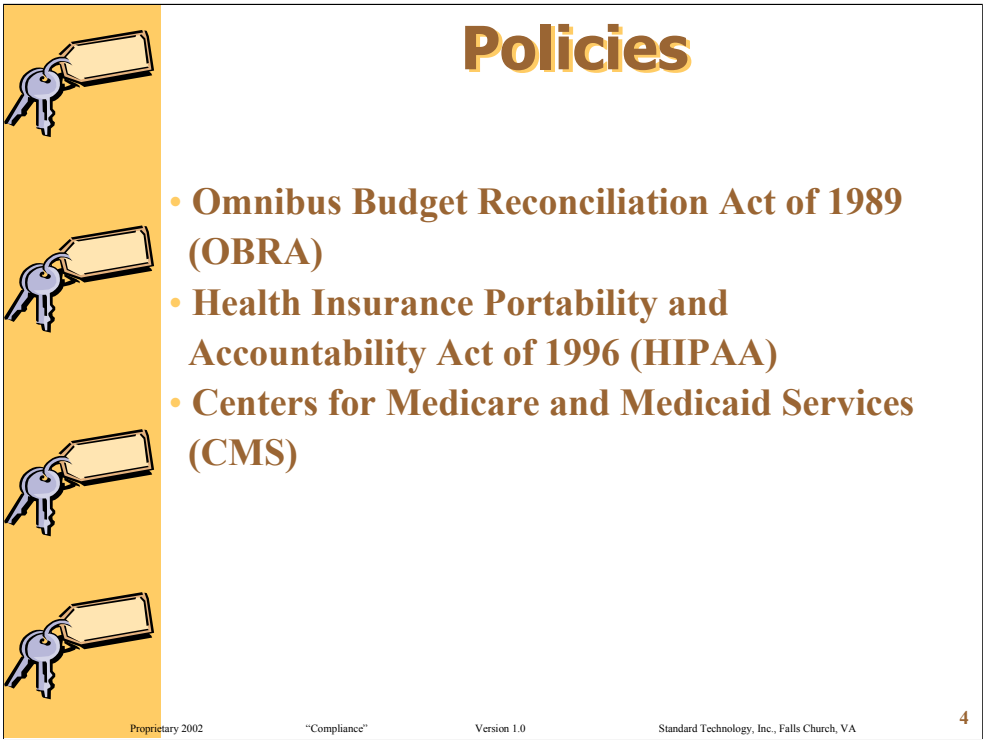


Objectives

- Define compliance
- Explain written policies governing compliance
- Discuss some benefits of compliance
- Define fraud and abuse and recognize target areas
- Explain consequences of non-compliance
- Provide steps for establishing Compliance Program
- Discuss importance of submitting *"Clean"* claims



- There are many billing and coding regulations required only by Centers for Medicare and Medicaid Services (CMS) formerly known as Health Care Financing Administration (HCFA):
  - It is important for Military Treatment Facilities (MTFs) to be aware of these regulations.
  - Many payers are now adopting CMS requirements and guidelines.



These are a few examples of policies that are used to enforce compliance issues.

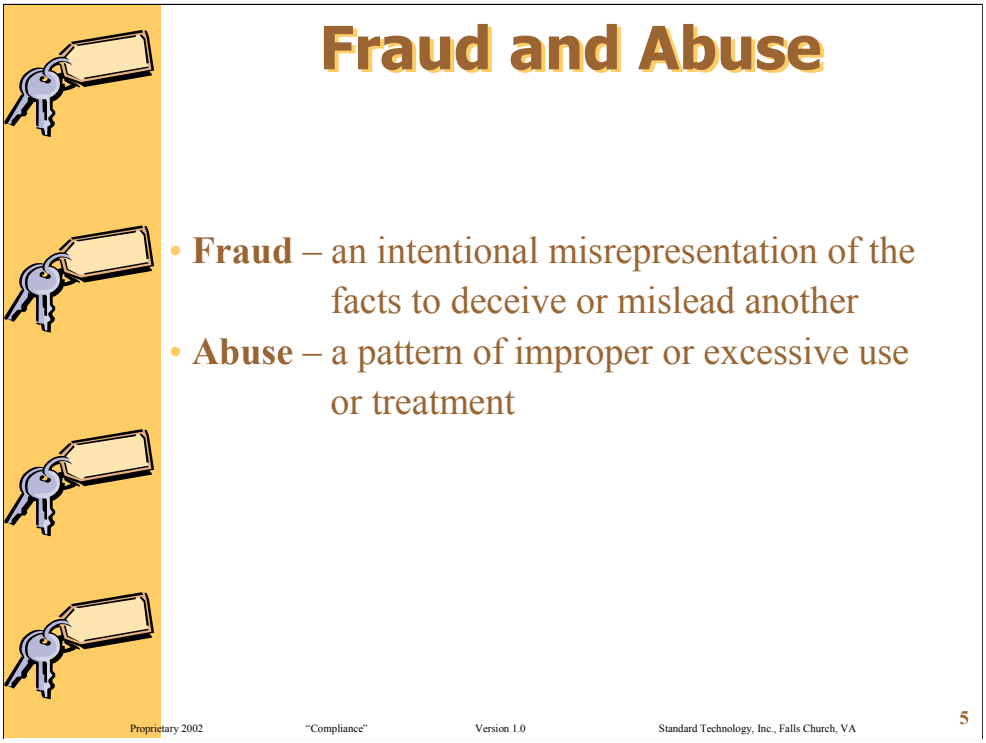
• **OBRA** is an act that defines false claims as "knowingly making or causing to be made a false statement or misrepresentation on any claim to the United States or any agency for payment."

• **HIPAA** – The provisions of this act are to improve the efficiency and effectiveness of the health care system in general:

  – Encourages the use of electronic methods for transmission of health information through the establishment of standards and requirements.
  – Deals with many privacy and security issues with the sole purpose of enforcing established policies.

• **CMS** is the federal agency within the Department of Health and Human Services that administers the Medicare Program and certain aspects of state Medicaid Programs:

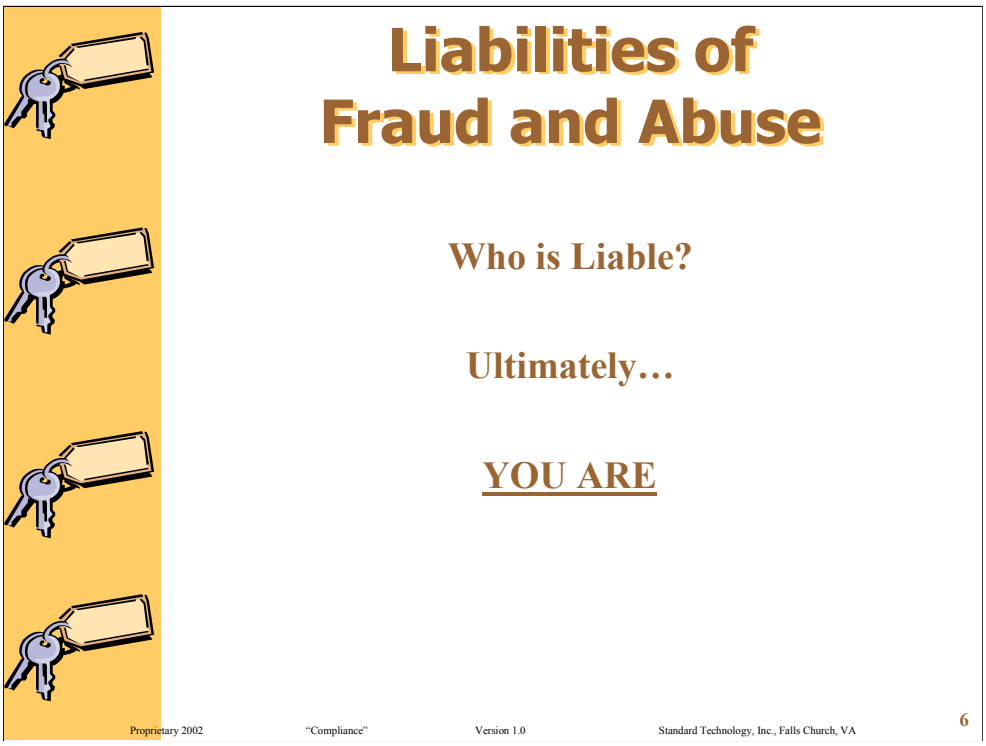
  – The Office of the Inspector General (OIG) encourages MTFs to be aware of the billing and coding regulations of CMS since many payers are now adopting them.



- Fraud and Abuse are the **primary factors** of non-compliance.

- **Examples of Fraud:**
  - False charges and unbundling
  - Billing for services not rendered
  - Altering claims for higher reimbursement
  - Inappropriate E&M code assigned to bill

- **Examples of Abuse:**
  - Identical E&M codes used for most visits when inappropriate
  - Continuous billing of unnecessary services
  - Violation of contractual agreement with third parties

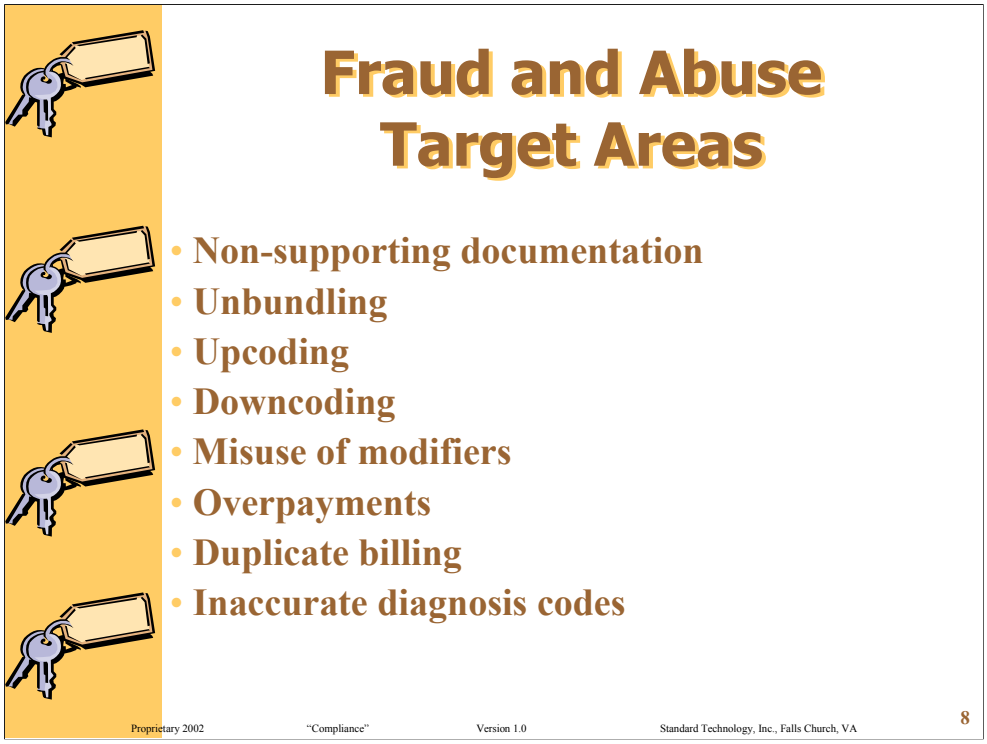


- Everyone is responsible for his/her functions. From the front desk staff, to the provider, to the coder, to the billing staff.

- The Federal False Claims Act not only penalizes those persons who submit false claims or make false statements, but also those persons who cause false claims or statements to be made or used.

- Adhere to the MTF's established billing practices and the rules and laws that govern them.
  - JCAHO
  - OIG
  - State Regulations

- Imprisonment is possible in severe cases.



- **Non-supporting Documentation** - When pertinent facts, findings, and observations do not support what is billed.

- **Unbundling** - The practice of a provider billing for multiple components of service that were previously included in a single fee.

- **Upcoding** - Using a billing code that provides a higher payment rate than the billing code that actually reflects the service provided.

- **Downcoding** - Submitting bills that are fragmented to optimize reimbursement through multiple billing of similar procedures.
  - Example: Selecting a lower E/M level that is not supported by the documentation.

- **Misuse of Modifiers** - Two providers complete a procedure, but one provider bills for the entire procedure without giving credit (using proper modifier) to the work that the other provider performed.

- **Overpayments** - Improper or excessive payment made to the MTF as a result of patient billing or claims processing errors for which a refund is owed by the facility.

- **Duplicate Billing** - When the MTF submits more than one claim for the same service (excluding re-submissions for follow-up) or the bill is submitted to the primary and secondary payer at the same time.

- By establishing a billing compliance program, the risk may be reduced if it pre-dates any investigation.

- **Inaccurate diagnosis** – adding an inaccurate diagnosis code to get the claim out the door is inappropriate.

• Ensure that one representative from each department is a member of the compliance team. Example, Pt. Registration, clinical staff/provider, coder and Pt. Accounts.

• Assign a knowledgeable person to be the compliance officer for the organization.

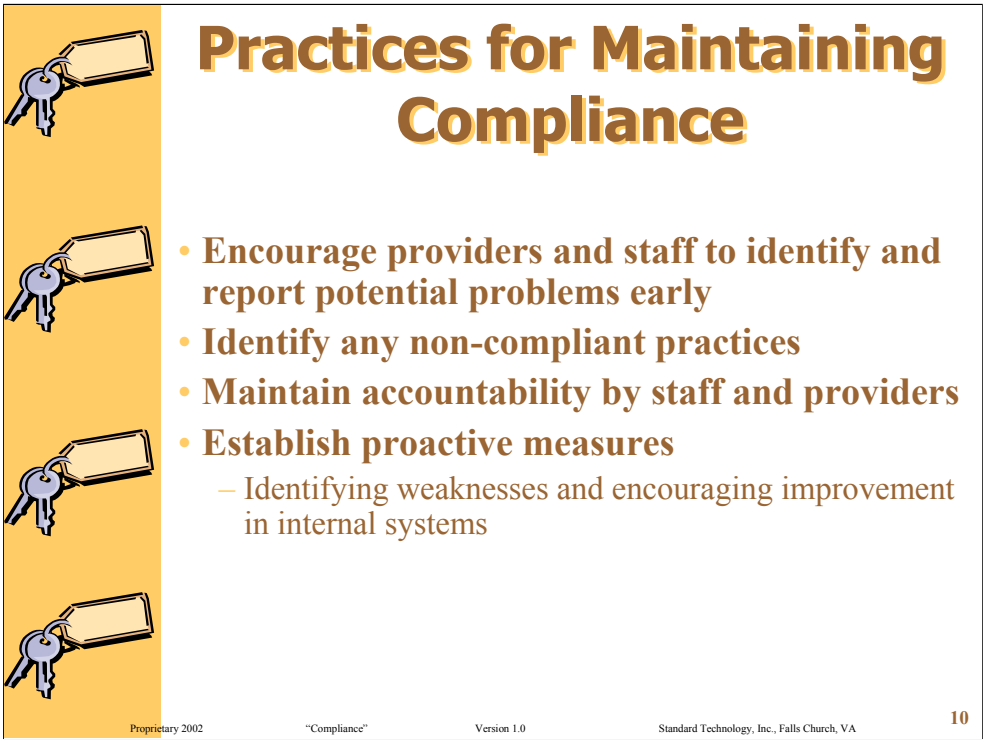
• Develop a plan of action that is achievable. Perhaps, you could monitor coding and/or billing practices on a weekly or monthly basis. The key is to be consistent.

• Develop some written guidelines as a way to track concerns within office practices or billing processes and to identify specific areas of risks or vulnerabilities.

• Use an assessment tool to conduct a baseline audit in each department and provide outcomes to the team. (Pay particular attention to the targeted areas.)

• Provide various types of training classes, seminars and conferences to enhance the staff's knowledge.

• As a guide, use the Compliance Manual issued at the1999 UBO Conference. Refer to the UBO website and download a copy, also, use the second web site for further details of the definition and components of compliance.



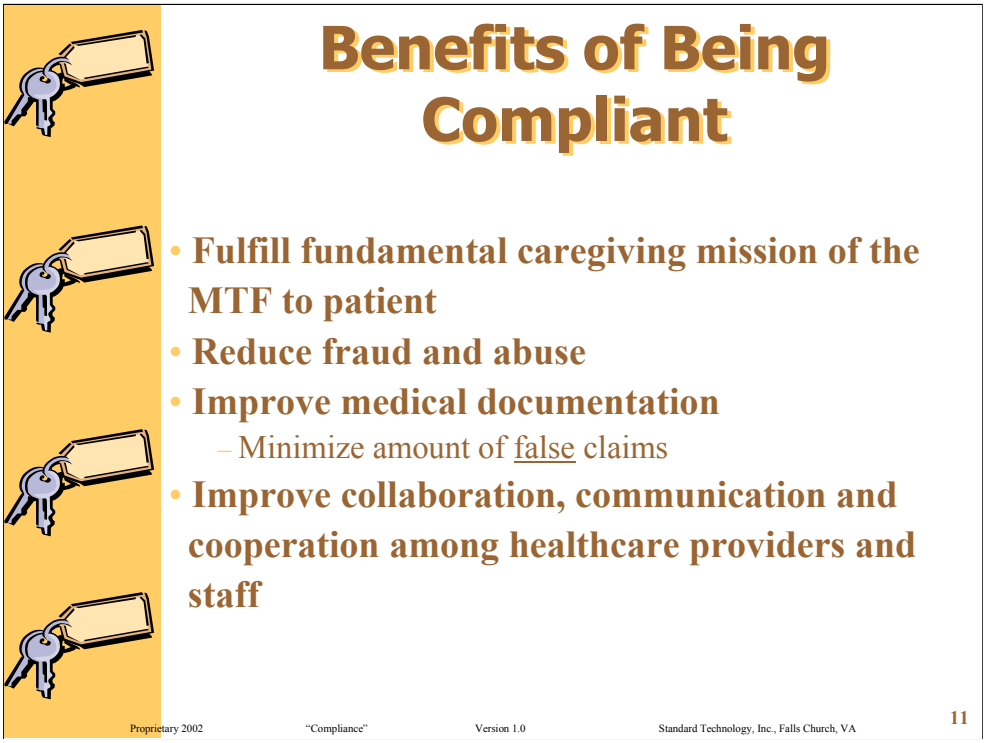
• Encourage staff to identify and address potential problems.

• Have members who are willing to stand by decisions and/or actions they have taken.

• Be proactive not reactive regarding problems.

• These practices should be ongoing.

• Do it right the first time.

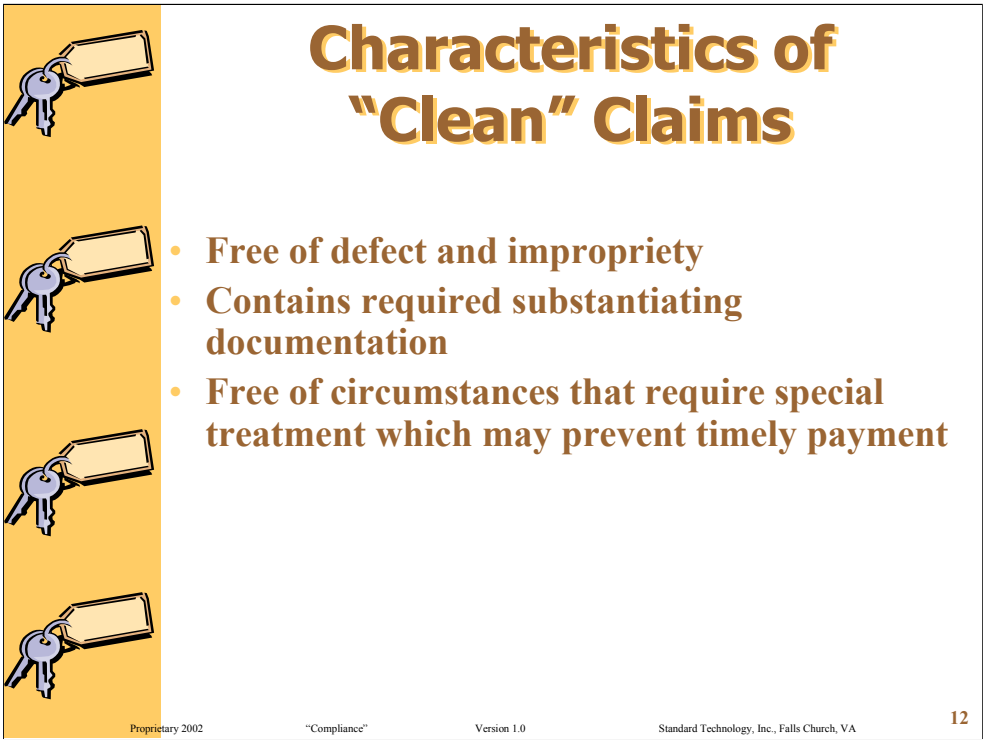


• Primary mission is to render quality health care.

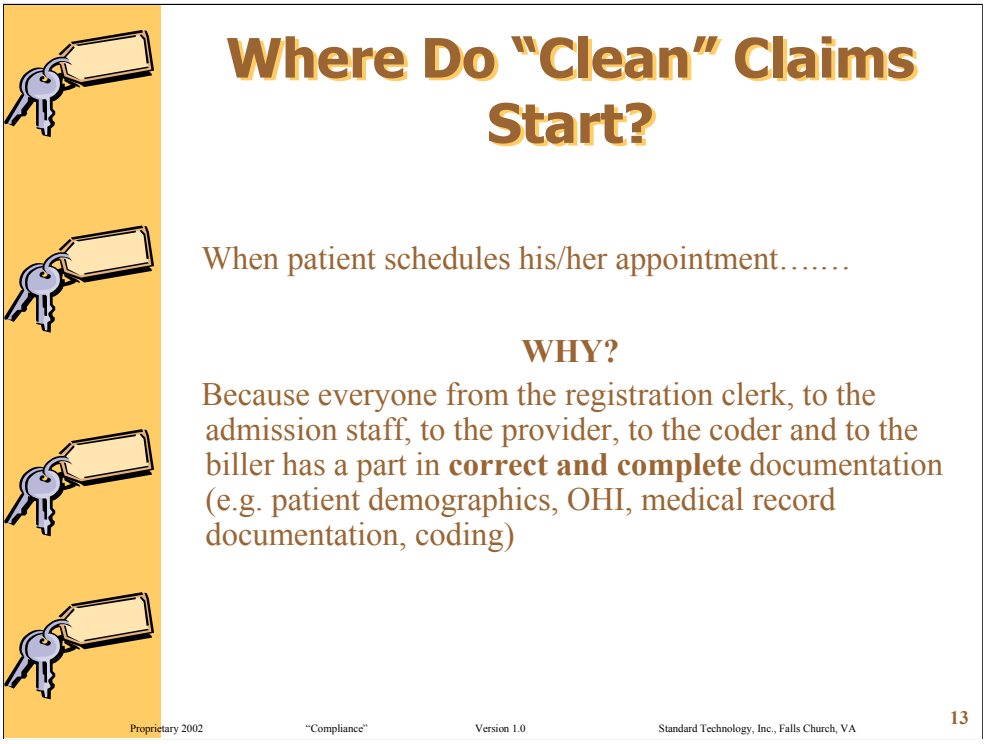
• Ensuring there are no patterns of wrong doing being established.

• Making sure all pertinent facts about a patient's encounter are being captured and documented.

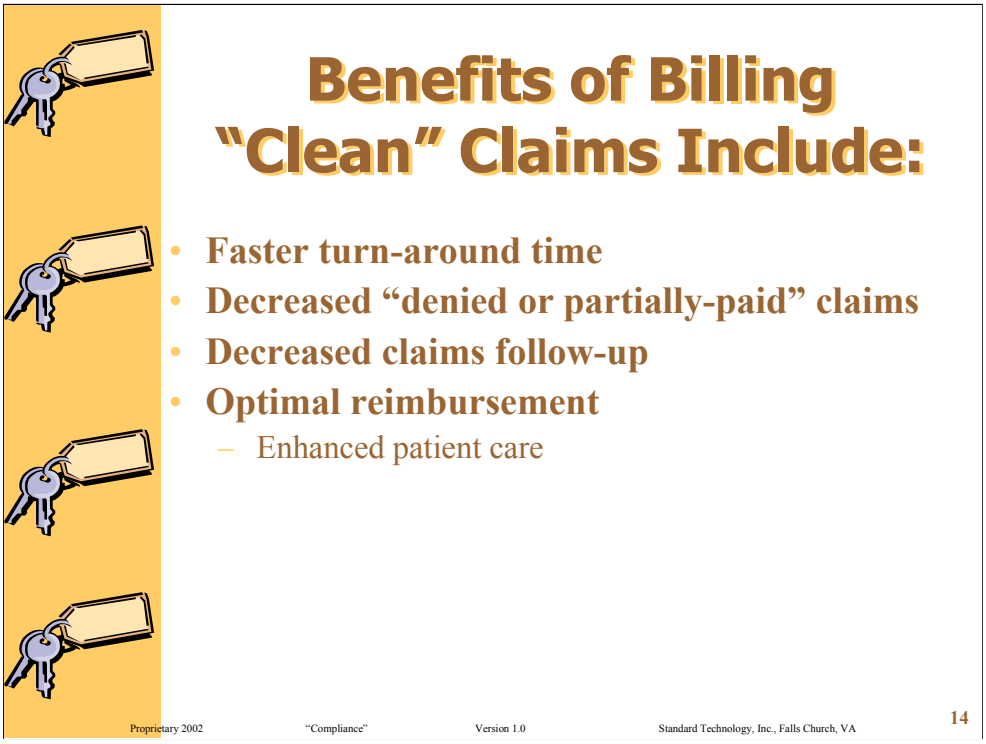
• Creating a cohesive group of caregivers who share a common goal to consistently carry out the MTFs mission.



- You must ensure that the claims are: (Read bullets on slide).



- **Note to Trainer:** Have the class refer to their Revenue Cycle Chart handout.



• These are just a few **examples** of what submitting clean claims can do for your facility:

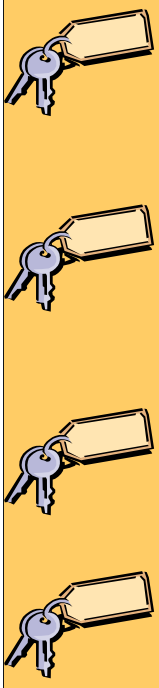
- **Payers** will experience fewer problems when processing claims.

- **Billers** will spend less time on follow-up, receive less audit exposure, and contribute to the revenue intake for the MTFs to enhance patient care.

- **Providers** will also receive less audit exposure because of proper/supporting documentation on their behalf that leads to accurate coding.

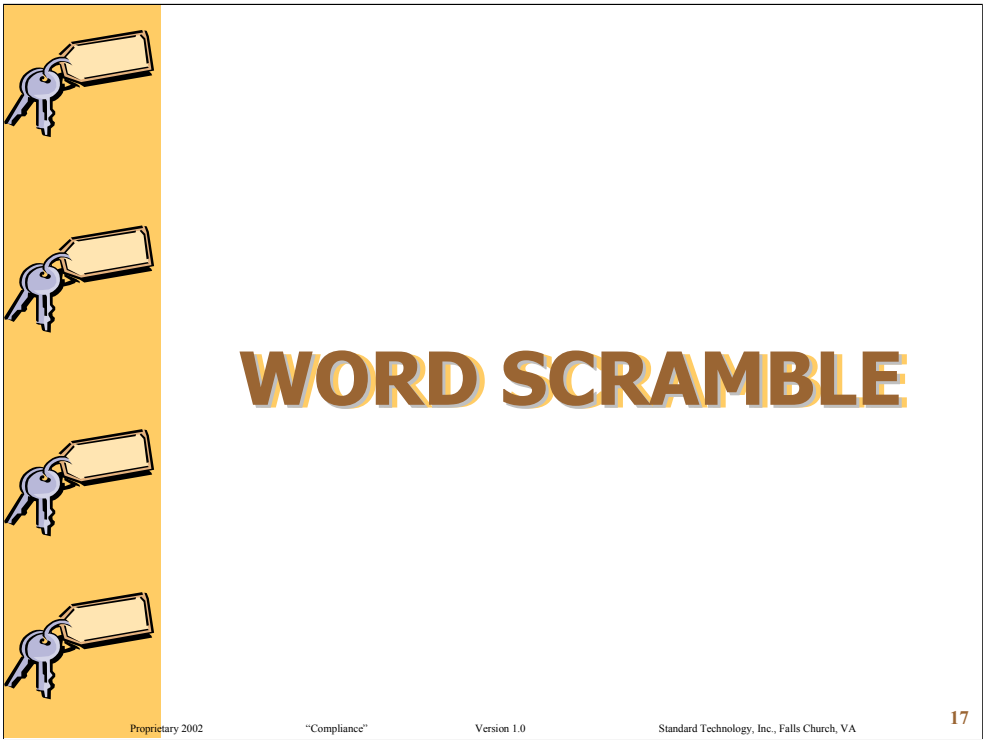
- **Patients** payment towards their deductible will be met sooner.

- Demonstrate these three functions:

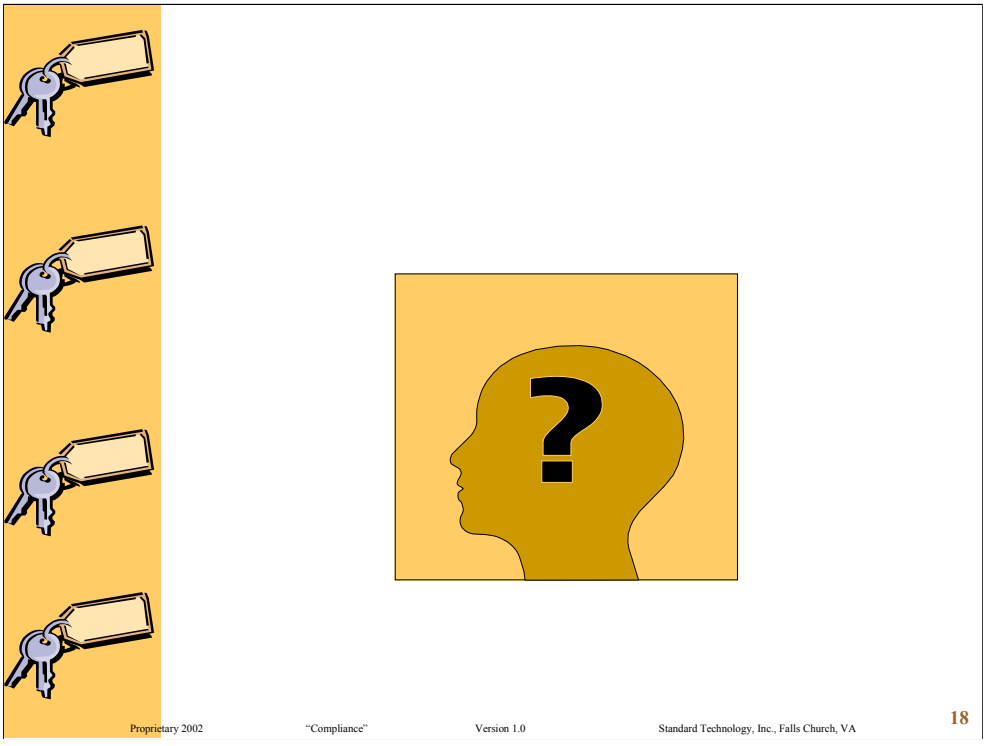


Key Points

- Practicing compliance is driven by the TEAM, not an individual
- As a trainer, you can bring the issue of compliance to the MTF team and:
  - Explore the current compliance program in your MTF with the team
  - Refer to the UBO web site at http://www.tricare.osd.mil



NOTE TO TRAINER: Distribute word scramble puzzle and allow 10-15 minutes for completion.



Proprietary 2002 "Compliance" Version 1.0 Standard Technology, Inc., Falls Church, VA

Compliance Audit Checklist

This Compliance Audit Checklist Template can be tailored to include your Service/MTF specific needs. The Compliance Audit Checklist Template is one of the elements of the Internal Control Review within an MTF. This checklist covers the main points of TPC, MSA, and MAC programs. If there are areas that do not apply to your facility, they can be deleted. At the same time if there are particular areas you wish to focus on that are not listed, they can be added. **This checklist is not meant to be inclusive of all guidelines and was designed based on results of various MTF audits. This audit is not intended to be repetitive or duplicative of other audits conducted within the MTF.** If some of these checklist items are already being assessed in other processes, then they do not have to be repeated. This checklist should be completed at least quarterly. If there are significant problem areas, a more frequent audit may be warranted. Non-compliant areas should be explained with a plan for correction of any problems. This is meant to be an internal tool and can be used to identify high-risk areas for process improvement. The audit checklist is part of your Compliance Plan and should also be utilized in business case analysis/reengineering initiatives for the Uniform Business Office. This checklist is a dynamic tool and updates may be found on the UBO website at: http://www.tricare.osd.mil. Go to the Browse by Topic and select UBO, then proceed to the Compliance page.

It is expected that all DoD personnel and agents mirror the high standards set forth in these guidelines and our actions consistently reflect the intent of the ethical guidelines contained in the checklist. We must demonstrate consistently that we act with absolute integrity in the way we accomplish our work. Compliance plans are implemented to assure avoidance of false claims or bill submissions to either a first or third party payer and assist facilities in identifying internal weaknesses and areas for improvement.

General

If the answer is indicated in the shaded area, please explain in the space provided at the end of the Audit Checklist. The checklist should be maintained in the compliance binder along with any implementation plan for process improvements to correct discrepancies or improve business operations.

No.	Question	Yes	No
1.	Does the Military Treatment Facility (MTF) have written standards for employees to address fraud and abuse violations for federal, state, and third party health care programs?[i, ii]		
2.	Does the MTF have written standards for claims documentation and fraud prevention for the UBO staff?[iii]		
3.	Does the MTF provide annual job-related education and training for all UBO personnel?[iv]		
4.	Does the MTF have written standards specifying clinical documentation requirements for the assignment of a code (e.g., CPTs, ICD-9-CM, etc.)?[v]		
5.	Do audits and monitoring of the UBO occur on a scheduled recurring (at least quarterly) basis?[vi]		
6.	Are the outcomes of audits and monitoring used as the primary criteria for evaluating the work performance of the UBO staff?[vii, viii]		

Internal Management Control

No.	Question	Yes	No
1.	Do any coders also perform billing functions simultaneously?[ix] [x]		
2.	Do any billers also perform coding functions simultaneously?[xi]		
3.	Are procedures in place to assure separation of coding and billing functions?[xii] (only need to address if answer to either of first 2 questions was "yes")		
4.	Are the applicable current OASD (Comptroller) published medical and dental rates used for billing eligible beneficiaries and third party payers?[xiii]		
5.	Are there policies and procedures in place regarding the creation, distribution, retention, storage, retrieval and destruction of documents related to the billing and coding process?[xiv] [xv] [xvi]		

Third Party Collection Program (TPCP)

No.	Question	Yes	No
1.	Are all potentially billable beneficiaries interviewed to obtain employment and insurance information?[xvii]		
2.	Are UBO personnel and other staff collecting insurance information receiving ongoing training in interviewing techniques?[xviii]		
3.	Are interviews documented on DD Form 2569, Third Party Collection Program – Insurance Information, and kept current in the patient record?[xix]		
4.	Are all DD Forms 2569 indicating billable insurance reviewed and benefits/amount of coverage verified with the payers and the results documented in both automated systems (CHCS & TPOCS)?		
5.			
6.	Are procedures in place to ensure pre-certification/pre-authorization actions occur and are documented?		
7.	Are all valid denials and refunds approved by the TPCP/Uniform Business Office (UBO) Manager or designated authority and appropriately and timely made?[xx]		
8.	Are appropriate insurance files maintained after discharge or ambulatory treatment to include DD Form 2569, copy of bill, copy of checks received, copy of correspondence and/or phone conversations, a copy of the concurrent review and continued stay review documentation, and a copy of the Explanation of Benefits (EOB)?[xxi] [xxii]		
9.	Are claim files maintained for the time period, and in the manner required by DoD 6010.15-M, the UBO Manual?[xxiii]		
10.	Are all claims for which payment is delinquent documented with actions taken and entered into a suspense file for follow-up actions?[xxiv]		
11.	Are clear and complete audit trails maintained on all claims forwarded to the appropriate RJA office for pursuit of invalid denials and medical affirmative claims?[xxv]		
12.	Is there a master file maintained on major employers, payers ,and HMOs in the area, and the specific benefits of such plans?[xxvi]		
13.	What are the 3 most common reasons for denial of claims since the last audit? _____ _____ _____		

No.	Question	Yes	No
14.	When is follow-up of partially paid or denied claims begun for inpatient _____ and outpatient _____?		

Medical Services Account (MSA)[xxvii]

No.	Question	Yes	No
1.	Is the Medical Services Account Officer (MSAO) appointed by written order of the MTF Commander?		
2.	Are Deputy MSAOs/-Assistant MSAOs, if required, appointed in writing by the MTF Commander?		
3.	Are procedures established for transfer of MSA accountability?		
4.	Is the MSAO accountable for any other appropriated fund or other Government property?		
5.	Are standard operating procedures established in writing for daily operation of the MSA office?		
6.	Is the organizational arrangement (separation of duties of biller, cashier, etc.) adequate to protect cash receipts?		
7.	Are DD Forms 7 and 7A prepared monthly and reflect TPC balance billing?		
8.	OCONUS (may apply to some CONUS locations): Are outpatient charges for civilians collected in advance of treatment except in case of emergency? (note that this item can be deleted under itemization and DoD 6010.15-M update)		
9.	When outpatient charge is not collected in advance, does the MSAO approve extension of payment period?		
10.	Does the MSAO have established follow-up procedures for collecting delinquent accounts?		
11.	Does the MSAO maintain a control register of assigned serial numbers of forms stored, issued to, and returned by the dining facility cashier?		
12.	Are adequate security containers available to safeguard Medical Services Account (MSA) funds and documents?		
13.	Are MSA cash collections deposited with the designated depository within 24 hours or the next business day?		
14.	Is cashing checks in excess of the person's debt prohibited?		
15.	Are current procedures established to ensure collections are distributed to the appropriate account and reconciled regularly with DFAS or MTF financial office?		

Medical Affirmative Claim (MAC)[xxviii, xxix]**,**

No.	Question	Yes	No
1.	Is there a system in place to identify and report to the appropriate Recovery Judge Advocate (RJA)/Staff Judge Advocate (SJA):		
	(1) inpatient treatment;		
	(2) outpatient treatment;		
	(3) supplemental care payments or other payments for care provided by a civilian source; and/or		

No.	Question	Yes	No
	(4) ancillary services ordered by an external provider, that are associated with an accident/trauma-related injury or illness (including active duty beneficiaries) for pursuing potential or ongoing Medical Affirmative Claims?		
2.	Are procedures in place to ensure the appropriate RJA/SJA is notified of (1) above? Note that this can be performed using a variety of sources including, but not limited to: DD Form 2569, list of admissions, copy of admission record, ADM form, clinic log, or other Service-specific Form/Log.		
	(1)		
	(2)		
3.	Is there a procedure in place to identify and report health care services for a non-federal employment related injury or illness (commonly referred to as workers' compensation) to the appropriate RJA/SJA?		
4.	Are procedures in place to:		
	(1) identify patients with concurrent TPCP and MAC claims,		
	(2) to pursue them simultaneously, and		
	(3) to notify the appropriate RJA/SJA in a timely manner		
	(4) that a TPCP health insurance payment or denial is received on a concurrent MAC claim?		
5.	Is there ongoing documented training for the administration of the MAC program?		
6.	Does the MTF receive a periodic report from the appropriate RJA/SJA listing MAC claims closed without recovery and claims transferred to another RJA/SJA jurisdiction?		
7.	Does the MTF receive and maintain a monthly report listing the patient's name, sponsor's SSN, and amount(s) deposited into the appropriate specified account?		
8.	Are procedures in place to ensure MAC related claim forms are accurately completed by the MTF and provided to the RJA/SJA, with copies of pertinent medical records, in a timely manner?		
9.	Does the MTF maintain documentation supporting MAC claims after treatment or discharge as addressed in DoD 6010.15-M, the UBO Manual, Chapter 5, Paragraph C, "MTF Responsibilities," regarding Internal Controls?, including, but not limited to:,		
	(1) UB92s		
	(2) encounter forms		
	(3) DD Forms 2569		
10.	Are procedures in place to ensure all requests from attorneys, insurance companies, and patients are screened for potential or ongoing Medical Affirmative Claims and these requests are forwarded to the RJA/SJA for release or approval for release?		
11.	Are procedures in place to ensure separation of duties, i.e., that MTF personnel performing MAC related billing functions are not also performing MAC related collection/deposit functions as addressed in DoD 6010.15-M, the UBO Manual, Chapter 5, Paragraph C, "MTF Responsibilities," regarding Internal Controls?		

Staff Performance and Training[xxx]

No.	Question	Yes	No
1.	How many coders does the facility employ? inpatient _____ Outpatient_____		
2.	Of these coders, what is the level of crendentialing[xxxi]? Write the number of those with this credentialing next to each block. RHIA (Registered Health Information Administrator) RHIT (Registered Health Information Technician) CCS-P (Certified Coding Specialist—Physician-based) CCS (Certified Coding Specialist) CPC (Certified Professional Coder) CPC-H (Certified Professional Coder--Hospital) Eligible for Credential Limited or no training (mostly self-taught/on-the-job experience)		
3.	Do all UBO personnel receive compliance training on at least an annual basis?		
4.	Is the training documented in each Staff Development Folder?		
5.	Do the job descriptions appropriately describe/define specific duties of UBO personnel?		

Medical Records Documentation[xxxii]

No.	Question	Yes	No
1.	Are medical records closed within 30 days?		
2.	Is the DD Form 2569 filed in the record?		
3.	Is the DD Form 2569 completed appropriately?		
4.	Is there a process in place to verify provider coding accuracy?		
5.	Is there coordination with the Data Quality Manager (or equivalent) when coding problems are identified?		

Health Information Management[xxxiii]

No.	Question	Yes	No
1.	Is there an internal audit for data quality with the Information System (IS) data?		
2.	Does the bill accurately reflect the care documented in the IS?		
3.	Does the IS contain the current rates information?		
4.	Is there a mechanism for security to maintain the confidentiality of patient information/records?		
5.	Are the appropriate back-ups (i.e. monthly, weekly, daily) being performed in a regularly scheduled manner to ensure data integrity?		
6.	Can records be easily located and accessed within a well-organized filing or alternative retrieval system?		

Billing[xxxiv]

No.	Question	Yes	No
1.	Does the bill accurately reflect the care documented in the medical record? *(Upcoding is the practice of using a billing code that provides a higher reimbursement rate than the code that actually reflects the service furnished to the patient)*		

No.	Question	Yes	No
2.	If unbundling occurs *(Occurs when a billing entity uses separate billing codes for services that have an aggregate billing code) is it appropriate to meet DoD billing guidelines*?		
3.	Is there inappropriate upcoding?		
4.	Is there appropriate resolution of overpayment?		
5.	Are provider identification numbers used appropriately to prevent improper billing?		
6.	Are billing procedures appropriate to prevent duplicate billing?		
7.	Are there written policies or Standard Operating Procedures (SOPs) in place for handling billing errors and denials?		
8.	Is all billing current, to include a regular and frequent processing of bills to prevent backlogs (i.e. Daily or every other day)?		
9.	Is the HCFA 24-Hour Rule/1 Day Payment Window Rule followed?		
10.	When inpatients are transferred are the bills appropriately adjusted to reflect transfer in lieu of discharge? Transferring MTF bills and collects full DRG (DRG wt x ASA rate = amount billed)		

Multi-Site Billing[xxxv]

No.	Question	Yes	No
1.	If the facility is contracting out the billing service (i.e., another facility or contractor is performing the billing and collection function), is the contracted facility or contractor (i.e., the facility performing the billing and collection function) ensuring that this function is being accomplished within appropriate compliance guidelines?		
2.	Is there an audit process in place for both the facility performing the billing function and the facility contracting the service to assess that record documentation supports claims developed?		
3.	Are billing records maintained separately for each site?		
4.	Are accounts receivable records maintained separately for each site?		
5.	Are quarterly metrics report data reported separately for each facility for which claims are processed?		
6.	Does the contractual agreement between facilities contain a provision that allows the contracting facility access to data necessary to assess the effectiveness of the TPCP for their patient population? Parent MTF should only have "read only access" to the satellite facilities' data.		

Coding[xxxvi]

No.	Question	Yes	No
1.	Do CPT codes accurately represent documented care?		
2.	Are CPT codes assigned consistently and appropriately?		
3.	Who evaluates coding personnel? _____		
4.	How often are coding personnel evaluated? _____		
5.	Do ICD-9 codes accurately represent documented care?		
6.	Do HCPCS codes accurately represent documented care?		
7.	Do E&M codes accurately represent documented care?		
8.	Do Revenue Codes accurately represent documented care?		
9.	How long does it take to code an episode of care?		
10.	Does the coder consult with the provider to clarify discrepancies?		

No.	Question	Yes	No
11.	Are modifiers appropriately used?		
12.	Is the coding consistent and appropriate for outpatient services rendered in connection with an inpatient stay?		

Accounting[xxxvii],[xxxviii]

No.	Question	Yes	No
1.	Are all payments applied to the appropriate account?		
2.	Are all checks received processed within 24 hours or the next business day?		
3.	Are all checks received stored in a safe, logged into a control register and deposited within 24 hours or the next business day?		
4.	Is the organizational arrangement (separation of duties of biller, cashier, etc.) adequate to protect cash receipts?		
5.	Is there a separate lockable cash drawer or box for each cashier, if more than one cashier?		
6.	Are invoice and receipt (I&R) files maintained per Service guidelines?		
7.	Is a control register maintained by serial number of I&Rs (Service-specific forms) received, issued and returned?		
8.	Does the MSAO verify data on the control register with the Admission and Disposition (A&D) Report and refer discrepancies to the A&D office?		
9.	Are there procedures to ensure the MSAO is notified when services are provided to pay patients?		
10.	Are unbilled (accrued) charges posted at end of month?		
11.	Is the Medical Service Activity Report reconciled monthly with the MTF Budget Analyst (or equivalent) and discrepancies brought to the attention of the Base Accounting and Finance Officer for correction?		

Please explain for any block that was indicated in the shaded area:

Date Completed: _____

Date Briefed to Data Quality Committee /Executive:

Name: **Title:**

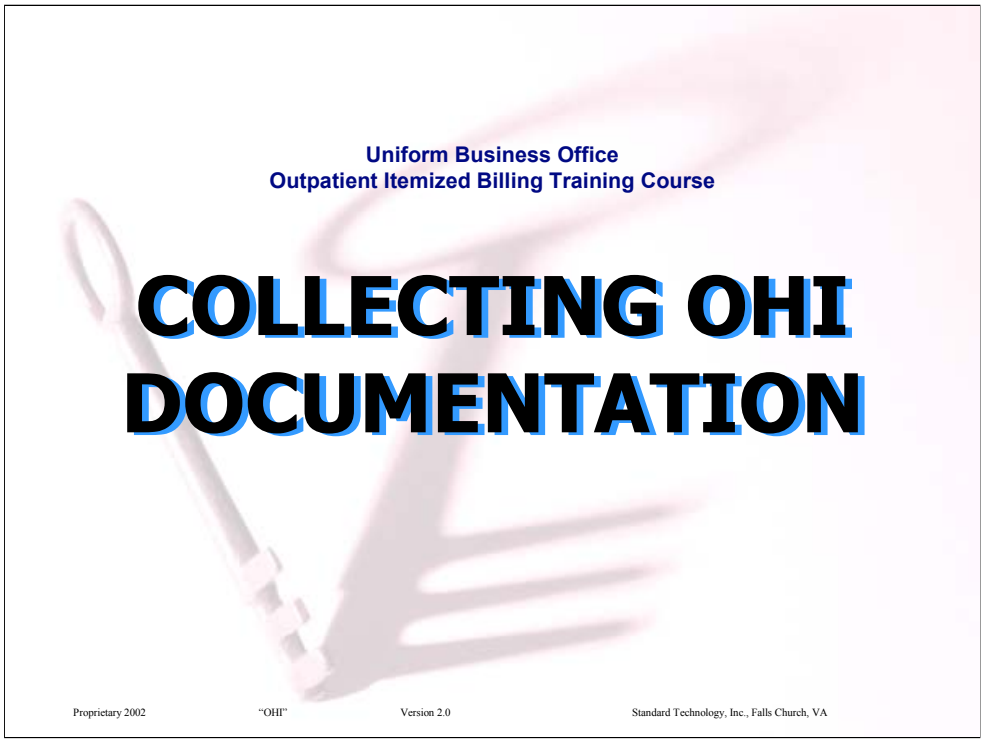
[i] DoD 6010.15-M Military Treatment Facility Uniform Business Office (UBO) Manual, Updated 2001 version, pending publication, UBO Compliance Plan guidelines.
[ii] Office of Inspector General (OIG) Compliance Program Guidance for Hospitals.
[iii] Ibid.
[iv] DoD 6010.15-M Military Treatment Facility Uniform Business Office (UBO) Manual, Updated 2001 version, pending publication, UBO Compliance Plan guidelines.
[v] Ibid.
[vi] Service-specific guidance.

[vii] Ibid.
[viii] OIG Compliance Program Guidance for Hospitals.
[ix] DoD 6010-15-M Military Treatment Facility Uniform Business Office (UBO) Manual, Updated 2001 version, pending publication, UBO best practices guidelines.
[x]In accordance with 10 U.S.C. 1095, Military Treatment Facilities (MTFs) are allowed to collect from third party payers the cost of health care services provided to DoD beneficiaries. MTFs are reimbursed for services rendered by billing the third party payers through the Third Party Collection Program; therefore, it is extremely important to have highly skilled personnel capturing the data necessary to create and process third party claims. Coders and Billers are two of the most important components of this reimbursement process, each having a specific skill requirement necessary for optimal reimbursement to the facility.

There would be a potential conflict-of-interest and considerable vulnerability for fraud if DoD allowed the practice of both billing and coding performed by the same individuals. Although Coders and Billers share certain knowledge, keeping each function separated lessens the facility's risk by ensuring TPCP compliance.

As an example, a biller is prohibited from adding a diagnosis code on a UB-92 claim form for pharmacy claims where the diagnosis code was not annotated on the original prescription. Educational programs reduce a facility's risk of non-compliance. To help ensure compliance and prevent facility fraud, waste, and abuse, coders, billers and their management require at a minimum annual training on: DoD ethics; fraud and abuse; and, coding and billing processing.
In accordance with Compliance and Audit and Evaluation guidelines in the Uniform Business Office (UBO) Manual, separation of functions (i.e., billing or coding) shall be maintained. A biller cannot code the medical record that supports the related claim. Likewise, a coder cannot prepare and send the claim or post the reimbursement. Each function is supervised by its chain of authority, e.g., coders by the Chief, Health Information Management/Medical Records; billing by the Uniform Business Office (UBO) Manager. It follows that correct coding should lead to correct billing.
[xi] Ibid.
[xii] Ibid.
[xiii] Section 1076(a) and (b) of Title 10, United States Code
[xiv] OIG Compliance Program Guidance for Hospitals, A. "Written Policies and Procedures," Section 8. "Retention of Records."
[xvxv] DoD 6010.15-M Military Treatment Facility Uniform Business Office (UBO) Manual, April 1997, Chapter 3, Section X. "Disposition of Records."
[xvi] Service-specific guidance.
[xvii] DoD 6010.15-M Military Treatment Facility Uniform Business Office (UBO) Manual, April 1997, Chapter 4, Section E, "Identification of Beneficiaries Who Have Other Health Insurance."
[xviii] Ibid. Section E. 3. "Interviewing Techniques."
[xix] Ibid. Section E. 1. "General Requirements."
[xx] Ibid. Section L. 4. "Validating Accuracy of Payments."
[xxi] DoD 6010.15-M Military Treatment Facility Uniform Business Office (UBO) Manual, April 1997, Chapter 4, Section E. "Identification of Beneficiaries Who Have Other Health Insurance," 1. General Requirements.
[xxii] Service-specific guidance.
[xxiii] DoD 6010.15-M Military Treatment Facility Uniform Business Office (UBO) Manual, April 1997, Chapter 4, Section I. "Collection Activities," 5. Disposition of Claims Files.
[xxiv] DoD 6010.15-M Military Treatment Facility Uniform Business Office (UBO) Manual, April 1997, Chapter 4, Section I. "Collection Activities," 1. Follow-Up Claims Inquiries.
[xxv] DoD 6010.15-M Military Treatment Facility Uniform Business Office (UBO) Manual, April 1997, Chapter 4, Section I. "Collection Activities," 2. Referral of Outstanding Claims.
[xxvi] Question was taken from U.S. Army Regional Claims Settlement Office (RCSO), Uniform Business Office (UBO) – Legal Services Site Visit Documentation.
[xxvii] DoD 6010.15-M Military Treatment Facility Uniform Business Office (UBO) Manual, April 1997, Chapter 3, Chapter 6, and Appendices B, C, D, E, J, K, et al.
[xxviii] DoD 6010.15-M Military Treatment Facility Uniform Business Office (UBO) Manual, April 1997, Chapter, 5, 42 CFR 2651-2653, and Service-specific guidance.

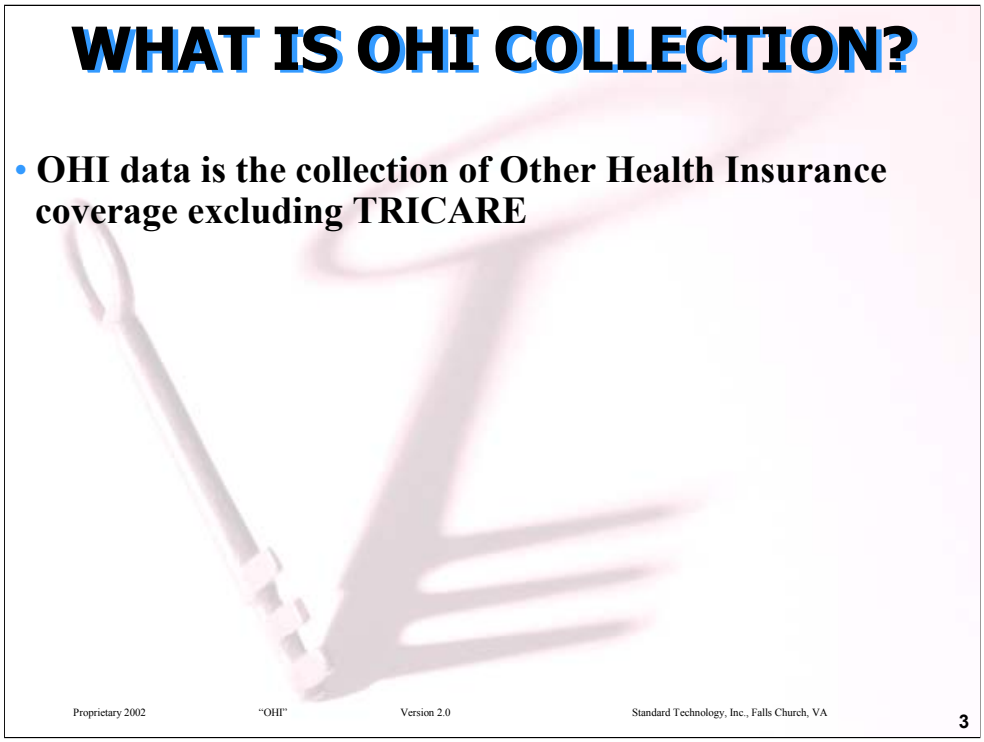
[xxix] Questions derived from Army-specific guidance. Other Service-specific guidance can be modified to meet rules, instructions, and guidelines for each Service.
[xxx] Meet Service-specific, and MTF-specific guidance.
[xxxi] Coding Certifications: Although there are no federal laws or regulations mandating the use of certified coders, coding professionals can be certified through two professional and certifying organizations. The two organizations representing health care coders are the American Academy of Professional Coders (formerly, the American Academy of Procedural Coders) and the American Health Information Management Association. The American Academy of Professional Coders (AAPC) was founded in 1988 in an effort to raise the professional standards of physician practice procedural coders by providing education, recognition, and certification. AAPC currently offers two coding certifications: Certified Professional Coder (CPC) and a Certified Professional Coder—Hospital (CPC-H). American Health Information Management Association (AHIMA) administers credentials and continuing education credits for medical records and health information practitioners. AHIMA has approximately 37,000 members, including Registered Health Information Technicians (RHITs) (formerly Accredited Record Technicians—ARTs) and Registered Health Information Administrators (RHIAs) (formerly Registered Record Administrators—RRAs). AHIMA also includes coder professionals among its ranks. They include Certified Coding Specialist (CCS) and Certified Coding Specialist—Physician-based (CCS-P).
[xxxii] Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) Standards and DoD 6010.15-M Military Treatment Facility Uniform Business Office (UBO) Manual, April 1997, Chapter 4.
[xxxiii] Composite Health Care System (CHCS); Ambulatory Data System (ADS); Third Party Outpatient Collection System (TPOCS); and other Commercial Off-the-shelf (COTS) products utilized at the MTFs.
[xxxiv] DoD 6010.15-M Military Treatment Facility Uniform Business Office (UBO) Manual, April 1997, Chapter 4.
[xxxv] Third Party Outpatient Collection System capabilities and Service-specific guidance.
[xxxvi] Health Care Financing Administration Medicare Coding Guidance; Department of Health and Human Services (DHHS) Office of Inspector General (OIG) Compliance guidance; DoD Coding Guidelines; and Ambulatory Data System (ADS) guidelines.
[xxxvii] Specific Army Accounting questions are provided as a reference. Service-specific guidance can be tailored for these audit questions.
[xxxviii] DoD 6010.15-M Military Treatment Facility Uniform Business Office (UBO) Manual, April 1997.



- TPC is an enormous untapped source of revenue.
- These lost dollars equate to equipment that MTFs do not buy, extra staff the MTFs do not hire, continuing education the MTF staff do not attend and pharmaceuticals the MTFs do not purchase for the pharmacy.
- Identification of Other Health Insurance (OHI) is a major component in recovering money for the MTF.
- Requests for OHI information must become a routine in the MTF.

OBJECTIVES

- Define OHI
- Explain new OHI system interfaces
- Identify what data is collected in patient interview
- Identify sources to collect non-disclosed data
- Explain confirmation of OHI data
- Explain what to verify for insurance carrier data
- Review some best practice ideas



- Under this program, MTFs collect from third party payers, such as insurance companies, for care provided by the MTF to non-active duty beneficiaries who are covered by commercial health insurance.

- It is vital to the success of the TPC Program for MTFs to optimize their collections through the accurate identification and confirmation of patients' insurance coverage.

STANDARD INSURANCE TABLE

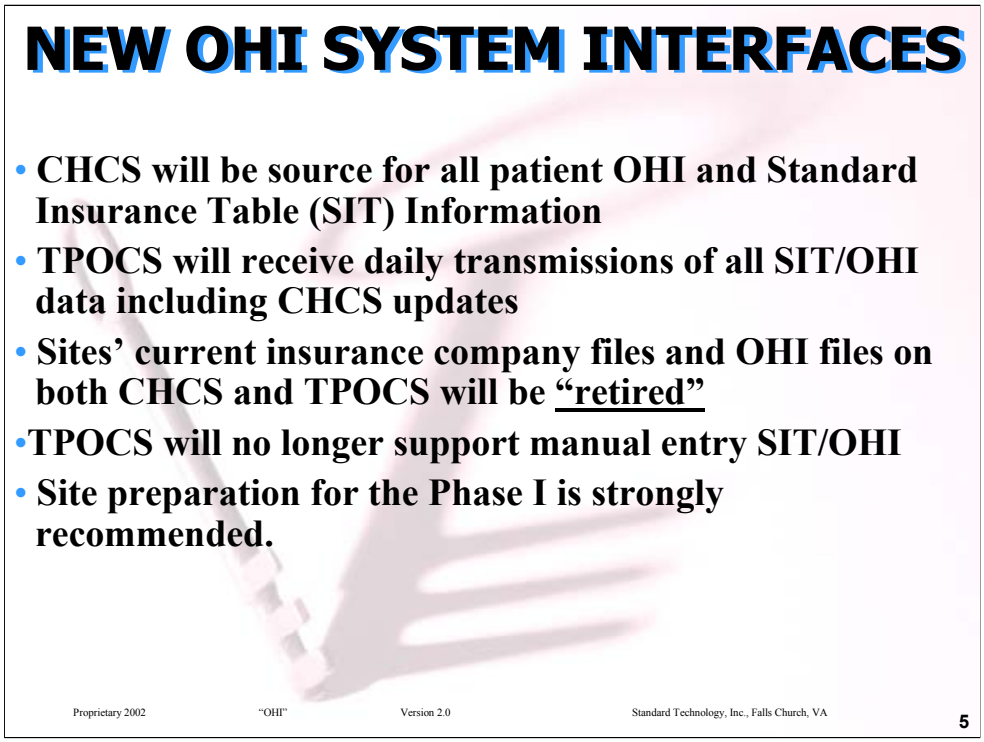
- **Phases of standardization:**

  - **Phase I:** Standardize the local SIT/OHI data between each site's CHCS and TPOCS databases; establish a uni-directional interface between CHCS and TPOCS for SIT/OHI data. Projected implementation date: August 2002.

  - **Phase II:** Establish a central repository on DEERS for SIT/OHI data; establish a bi-directional interface between CHCS and DEERS for SIT/OHI. Projected implementation date: To Be Determined.

- These phases will appear **seamless to the biller**, and will be further discussed in systems training; CHCS will push SIT information to TPOCS.

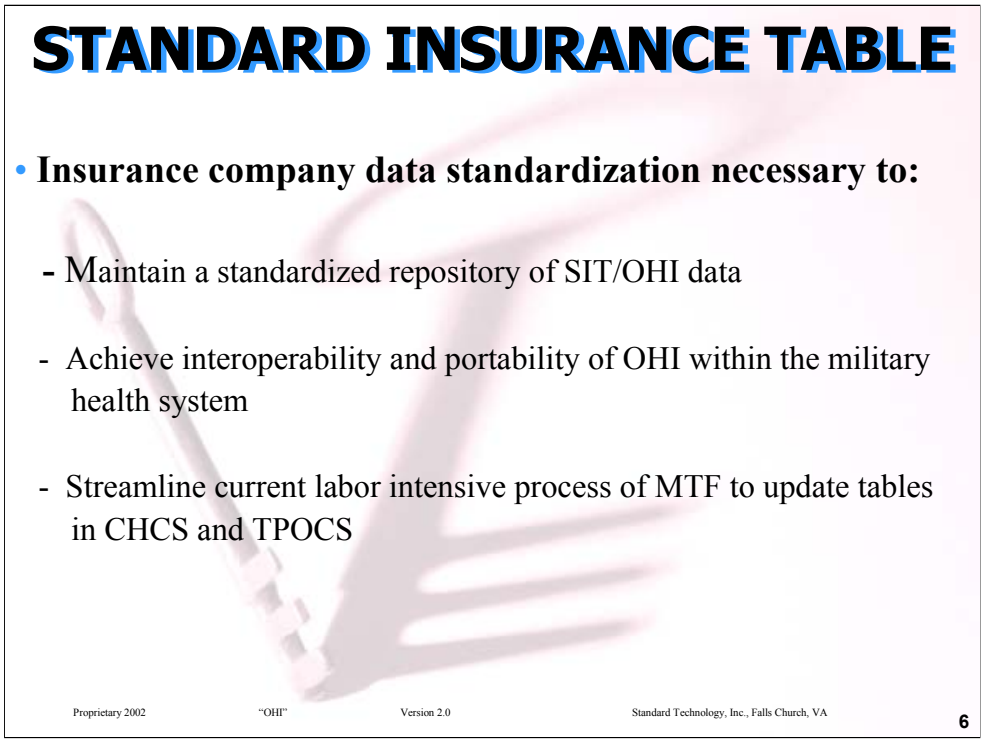
- If a user needs to enter new insurance company information into the SIT, the entry will be marked as a temporary record. Local SIT file administrators will send SIT update requests to the TMA Verification Point of Contact.



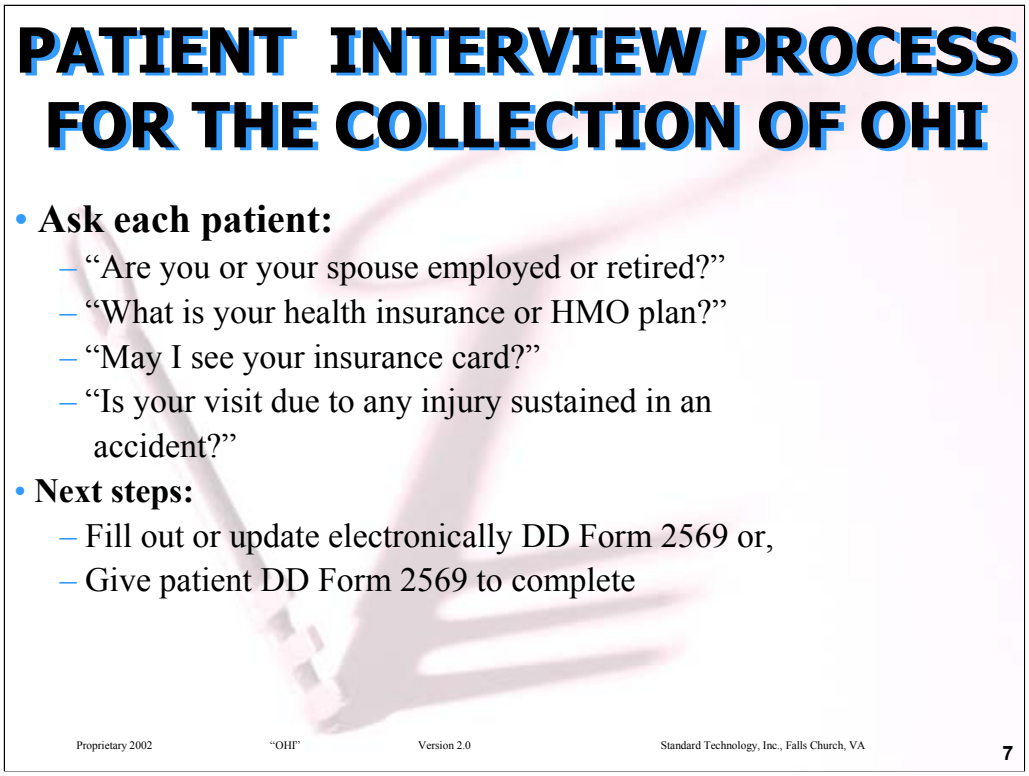
- With the move to Outpatient Itemized Billing, TPOCS will have an expanded functionality to include Itemized Billing and enhanced interface capabilities to support new policy and business procedure changes.

- When the insurance company and OHI Data is "retired" on CHCS and TPOCS, the retired files will be viewable but not be available for creating new claims.

- **TPOCS will no longer support manual entry SIT/OHI,** because all of the SIT and OHI information will be entered into CHCS then passed via daily updates to TPOCS.
- **Site preparation for the Phase I is strongly recommended.** This effort will require dedicated staffing resources to:
    - Manually synchronize their insurance company and OHI data so that their current CHCS insurance and OHI files mirror the good data (and linkages) that exist on TPOCS.
    - If sites have performed the above task, they will be able to update inactivated OHI data by using a "re-select and copy" function in CHCS, rather than re-entering all OHI data when the patient presents for services.
    - The actual first release of the SIT file will be provided to the sites prior to Phase I Implementation. Sites can compare their current database of billed insurance companies to those listed on the SIT, create a "crosswalk" matching their entries' short name to the standard name for future reference and also identify any entries on their local files that are missing from the SIT. Sites may submit SIT add requests to the TMA POC. (patrick.hamilton@tma.osd.mil).
    - More detailed information on the "SIT Transition" will be available in the SIT Transition Guide (estimated release date is EOM April 2002).



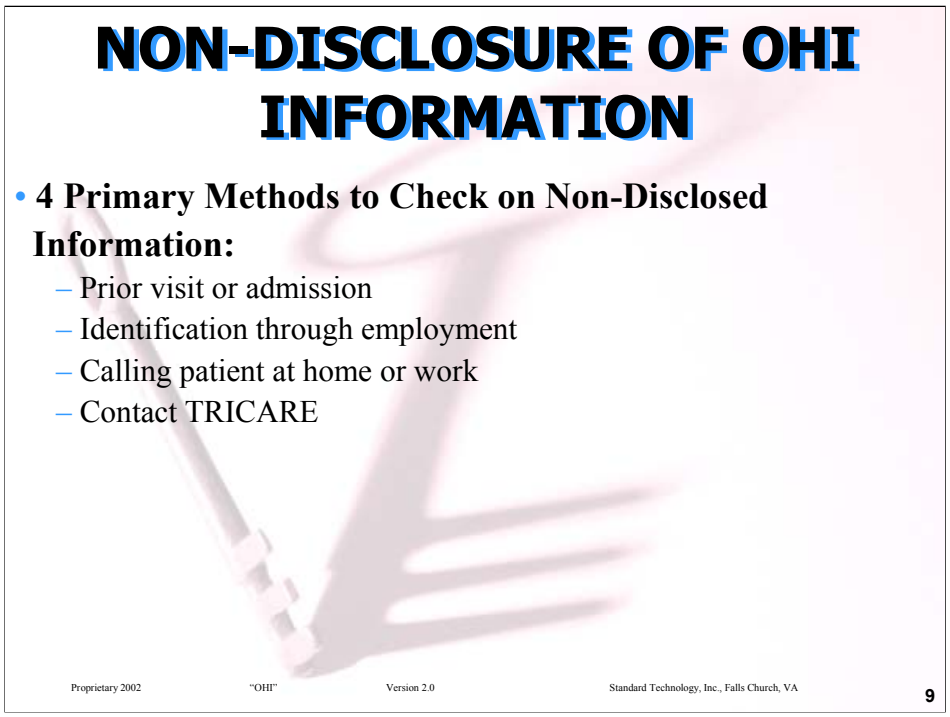
- A standardized repository of SIT/OHI provides the most current data to any MTF where the patient may be seen; facilitates collections.
- Portability of health information is a requirement of HIPAA.



- The interview is the most critical part in the identification of OHI.
- It is very important to take the time to conduct a personal interview with each patient.
- Help patients realize that their co-pays and deductibles are being met with no out-of-pocket expenses when they disclose OHI data.
- Because of high patient volume and the short length of time the patient is in the clinic, OHI information can be difficult to obtain.
- During the interview, ask the patient direct, face-to-face questions about their health insurance.
- You should have all patients answer these questions, even if they have indicated that they do not have OHI.
- If you are unable to obtain information prior to the patient's visit, follow-up with the patient either at home or at work.
- Continue to follow-up until you contact the patient and gather his/her insurance information.

PATIENT INTERVIEW PROCESS

- Ensure patient completes, signs and dates form
- Review completed form with patient
- Place copy of DD Form 2569 in patient's medical record
- Submit original DD Form 2569 to appropriate TPC staff



• Insurance information disclosure is voluntary (as stated on the DD Form 2569).

• Sometimes patients with OHI will not indicate their coverage during the interview process.

• Your follow-up with those patients is essential to maximize OHI identification.

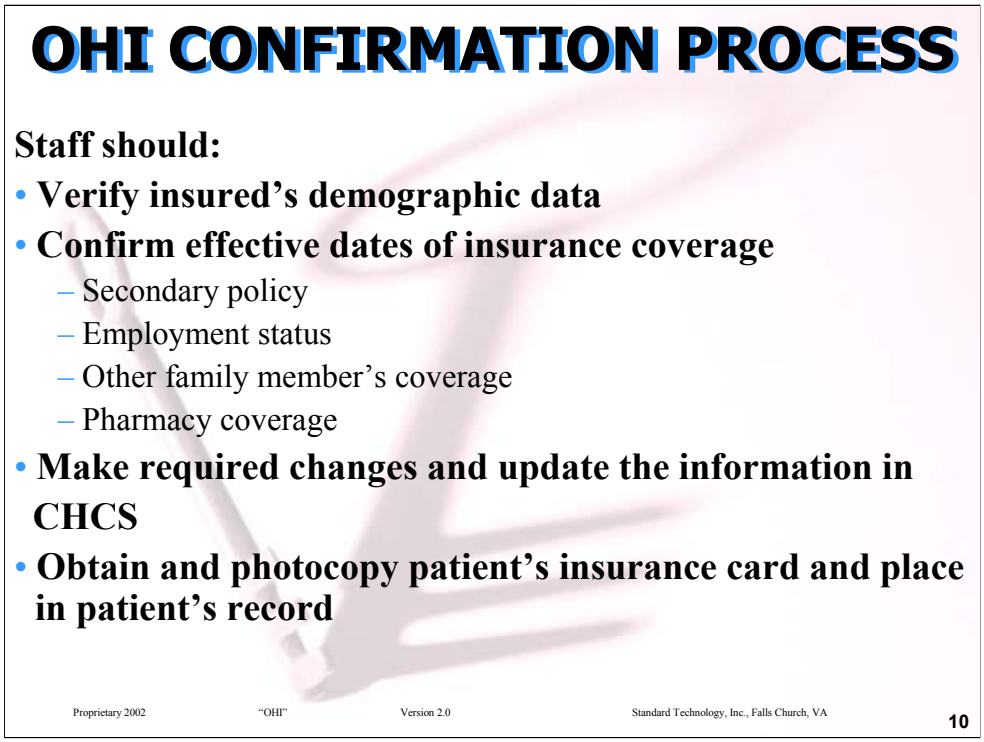
• There are 4 primary methods you can use to check for non-disclosed OHI information:

- Prior visit or admission information - check CHCS and TPOCS for prior admissions by patient, other family members, or spouse and verify with patient, employer or insurance company for current information.

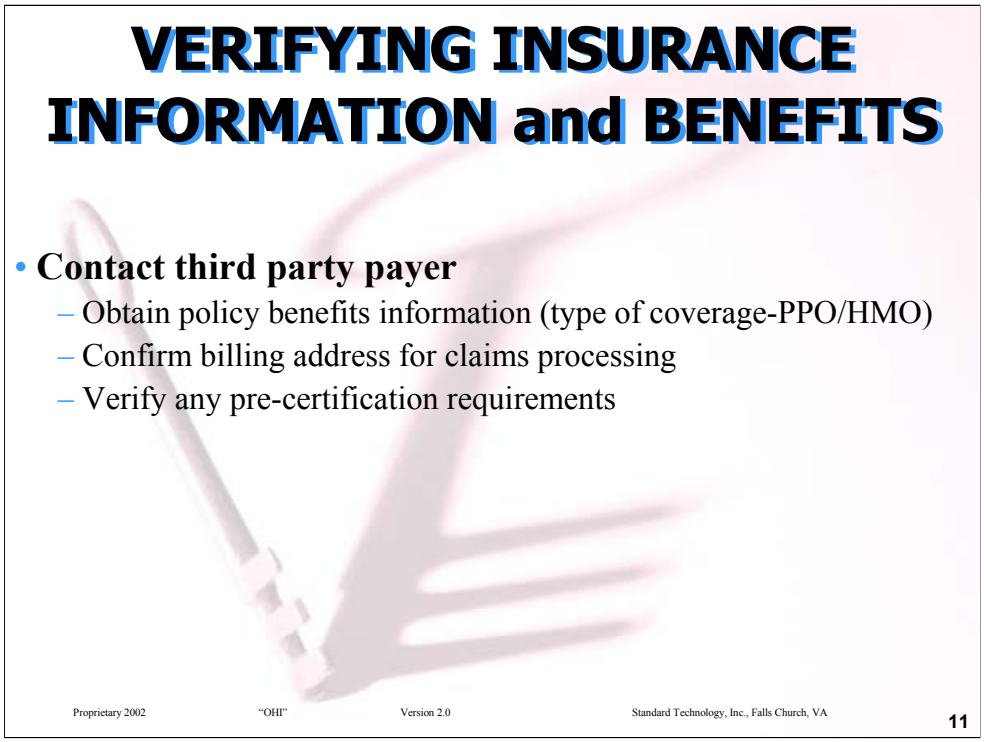
- Identification through employment - Employment provides majority of commercial OHI.

- Calling patient at home or work prior to admission or visit - caller can also use the opportunity to remind patient of his/her scheduled visit or admission.

- Contacting your TRICARE office to inquire about patient's OHI status



- You can ensure the correct information is passed on to the billing office for processing the claim by verifying the information received from the patient or other source.



- In order to verify the insurance information obtained from the patient during the interview process, contact the insurance carrier and confirm that all information is correct.

BEST PRACTICE IDEAS

TO HELP OPTIMIZE OHI COLLECTIONS SOME MTFs HAVE

- **Appointed staff members to help obtain OHI <u>prior to patient's actual procedure or appointment</u> by using:**
  - Registration Clerks
  - Admission Clerks
  - Appointment Clerks

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- It is important to obtain OHI information when the patient schedules an outpatient appointment and/or procedure, or when the patient presents to the clinic for services.

- Remember the main goal is to collect OHI information for as much of your patient population with alternative health insurance as possible.
- Use your team members to help brainstorm innovative ways to change how you currently collect OHI information.

BEST PRACTICE IDEAS

TO HELP OPTIMIZE OHI COLLECTIONS SOME MTFs

- **Provided DD Form 2569 to beneficiaries in pharmacy to be filled out while pharmacy fills patient medications**
- **Utilized part-time staff to collect OHI data in pharmacy during peak hours**
- **Updated OHI data at facility special events (e.g., Health Fairs)**
- **Mailed DD Form 2569 to each patient annually and then updated CHCS based on results**

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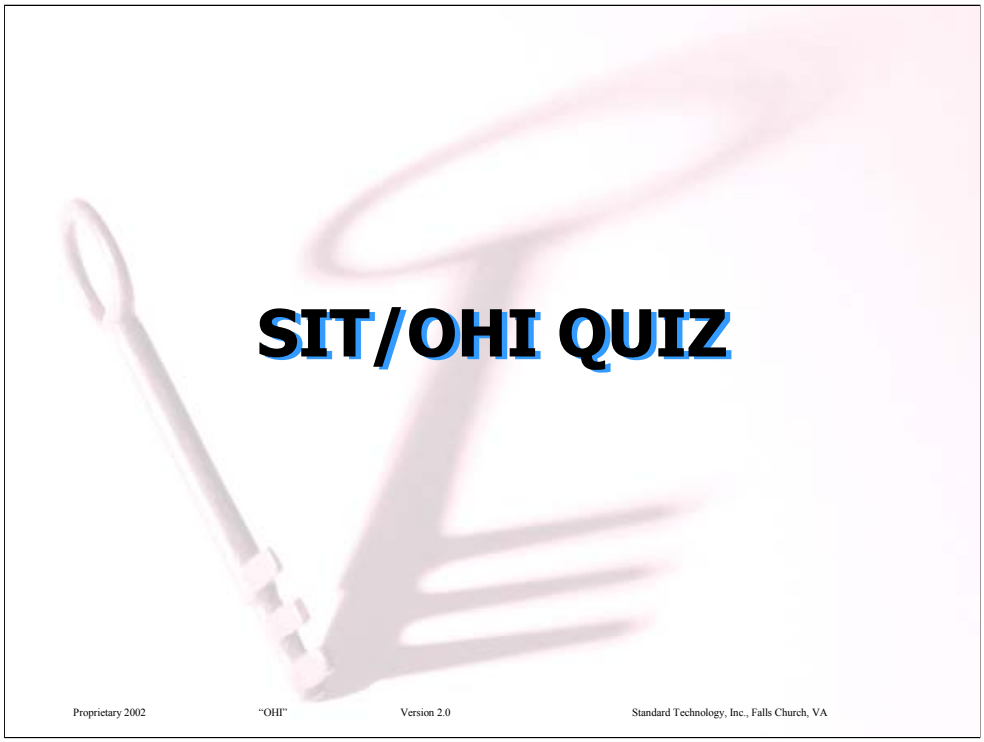
- The MTF Commander, managers, and line staff all need to understand the importance of collecting OHI and the impact these collections can have on the MTF mission.

KEY POINTS

- **CHCS is the standardized repository for SIT/OHI data**
- **It is imperative to train clinic staff, receptionists, etc to capture OHI at the onset of the patient's appointment**
- **Entering OHI data into TPOCS after the encounter is no longer possible**
- **Capturing OHI is a collaborative effort and marketing the importance of initial collection is necessary to avoid back-tracking and lost revenue**

- The MTF Commander, managers, and line staff all need to understand the importance of collecting OHI and the impact these collections can have on the MTF mission.

COLLECTING OHI OPTIMIZES REIMBURSEMENT FOR BETTER PATIENT CARE!


SIT/OHI QUIZ
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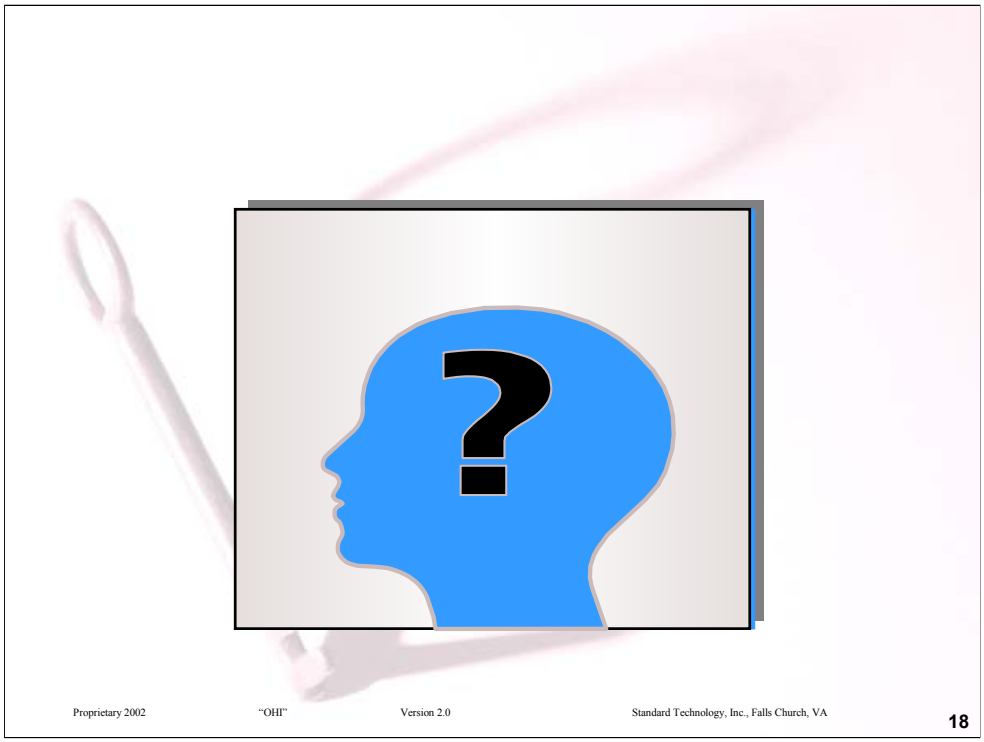

NOTE: Have participants turn to the "OHI Documentation" quiz. Allow participants 5 minutes to finish. Go over correct answers.

OTHER HEALTH INSURANCE (OHI) DOCUMENTATION REVIEW QUIZ

Please answer the following TRUE or FALSE questions pertaining to OHI Documentation

1. There will be systems changes with Outpatient Itemized Billing. TPOCS will no longer support manual entry OHI information.
   T_____ F_____

2. The patient interview process is an important component of collecting OHI. The interview should begin with the question, "Do you have other health insurance?"
   T_____ F_____

3. The verification of OHI consists of contacting the third party payer to confirm policy benefits, billing address, and any pre-certification requirements.
   T_____ F_____

4. Only patients who have indicated they have OHI should participate in the patient interview process.
   T_____ F_____

Please answer the following questions by filling in the blanks.

1. _____ will be the source for all patient OHI and SIT information.

2. DD _____ is the form used to capture OHI information.

3. Methods to check for non-disclosed OHI information are:

   _____,

   _____,

   _____, and

   _____.

4. Cite one "Best Practice Idea" to help optimize OHI collection.

   _____

   _____

OHI QUIZ KEY

True or False

1. True
2. False
3. True
4. False

Fill in the Blanks

1. CHCS

2. DD Form 2569

3. a. Prior visit or admission information,
   b. I.D. through employment,
   c. Calling patient at home or work prior to visit or admission,
   d. Contacting TRICARE office

4. Update OHI data at facility special events, utilize part-time staff to collect OHI data
   In pharmacy during peak hours, mail DD Form 2569 to each patient annually and then update
   CHCS based on results…


Uniform Business Office
Outpatient Itemized Billing Training Course
MTF and Payer Concerns
Proprietary 2002
"MTF and Payer Concerns"
Version 1.0
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Objectives
• Identify why claims are not paid
• Explain MTF concerns
• Explain Payer concerns
• Review systems impact on the MTF and Payer
• Provide recommendations for satisfying MTF and Payer Concerns
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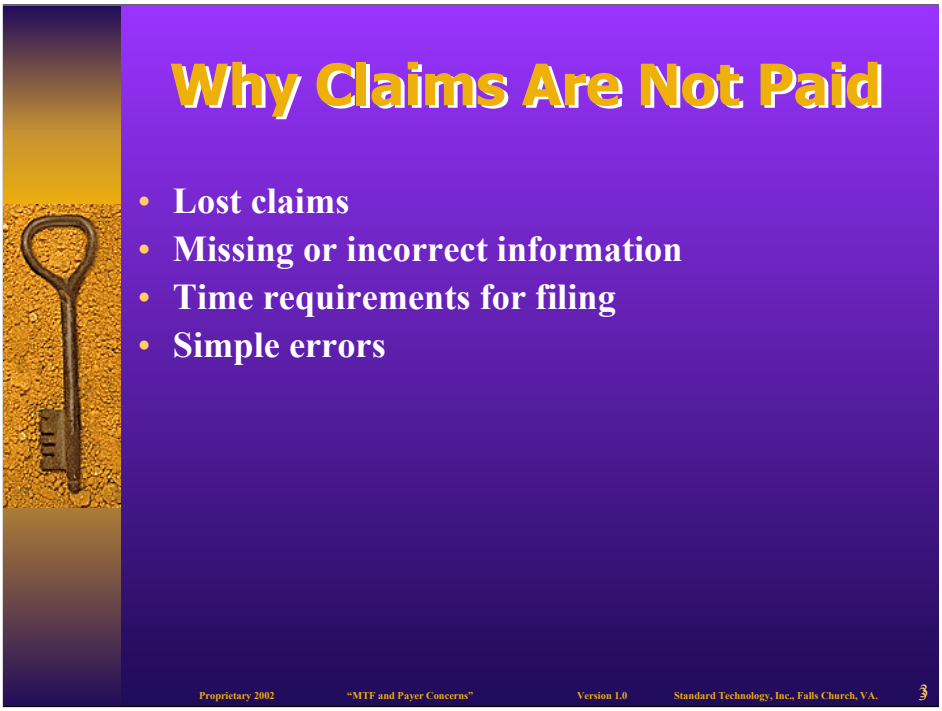


• **Lost Claims:**

– Thousands of claims are lost on a daily basis which equates to delayed or denied reimbursement due to timely filing issues.
– In most cases the payer assumes no responsibility for the lost claims citing that the claims were never received.
– The correct name and address of the payer is very essential to avoid this issue.

• **Missing or Incorrect Information:**

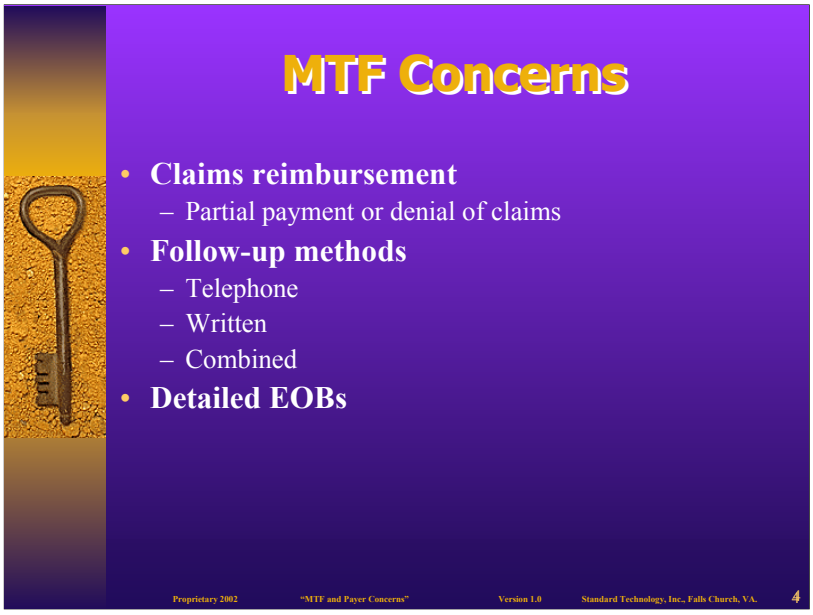
– All required information must be submitted for the claim to be classified as a "clean" claim.
– It has been estimated that 30% of all claims submitted to third party payers contain missing or incorrect information.
– Third party payers usually reject the claim with the appropriate denial code indicated on the EOB or Remittance Advice.
– Therefore, proper follow-up is required in order to get the claim properly adjudicated.

• **Time Requirements for Filing:**

– Third party payers usually require the claim to be received and processed within a 30, 60, or 90 day time frame.
– Proper follow-up must be made for these unpaid claims to avoid the claim being denied for being submitted after the filing deadline.

• **Simple Errors:**

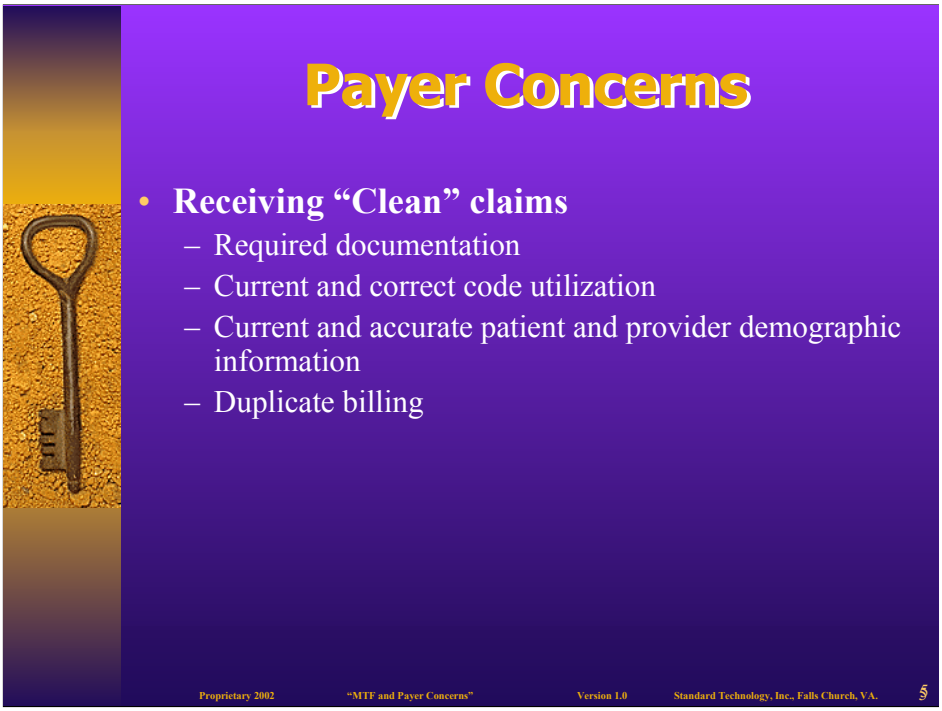
– When submitting claims to third party payers, it is very important to pay attention to detail to avoid simple errors such as: Incorrect provider number, incorrect or missing place of service, etc.
    • However, on some occasions, the Payer's staff contribute to this problem as well.



• **Claims Reimbursement:**
  – **Valid** reduction of payment or denial of claim
    • It is very important to verify the payments from third party payers to determine if they have reduced or denied reimbursements for valid reasons only.
    • Valid reasons for reduction include coinsurance, copays, and deductibles.

  – **Invalid** reduction of payment of denial or claim
    • If the third party payer indicates an invalid reason for denial, proper follow-up must be made to rectify the discrepancy and receive the correct reimbursement.

• **Follow-Up Methods:**
  – **Telephone:** This is the best way to obtain information about the status of outstanding claims
    • When using this method, it is very important to keep detailed logs documenting every telephone contact made to payers.
  – **Written:** This method provides a low-cost alternative to telephone contact
    • The follow-up letter should contain all relevant claim information and a copy of the original claim.
    • This is very effective because it provides proof of follow-up, showing that there has been a good faith effort to resolve a problem claim.
  – **Combined:** This method is the best way to counter the disadvantages of telephone and written follow-ups
    • The first attempts to follow-up should be written and until the claim is 90 days past due.
    • Then, telephone contact should be initiated and continued every 30 days until the claim is transferred to legal.
• **Detailed EOBs:**
  – EOBs from payers will be easy to read and understand because they will be itemized by procedure/service.
  – Providers and patients will be more informed of the specific procedures, charges and reason for payment/denial or pending status of each line item.



• **Receiving "Clean" Claims:**

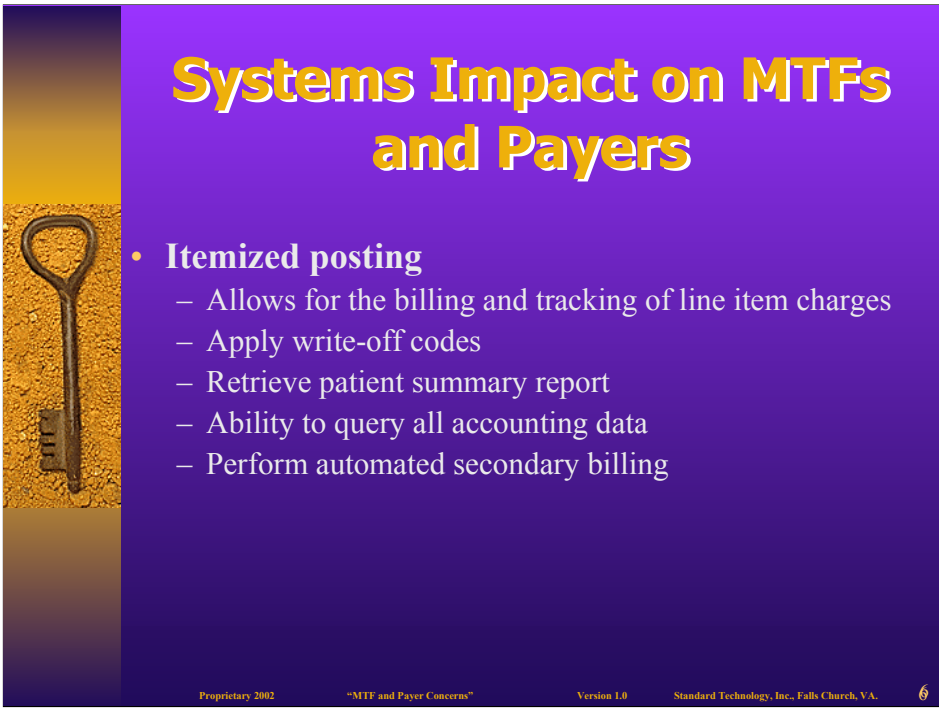
– **Required documentation:** All necessary documentation must be provided in order to appropriately process the claim in a timely manner.

– **Current and correct code utilization:** Current CPT-4/HCPCS codes must be used and adherence to correct coding guidelines is important to avoid unnecessary pending or denied claims.

– **Current and accurate patient and provider demographic information:** Payers must be informed of all updates to the patient and provider records in order to properly adjudicate claims.

• **Examples:**
  – Patient name and address
  – Provider name and address
  – Patient benefit package information
  – Patient or provider status (active/inactive)

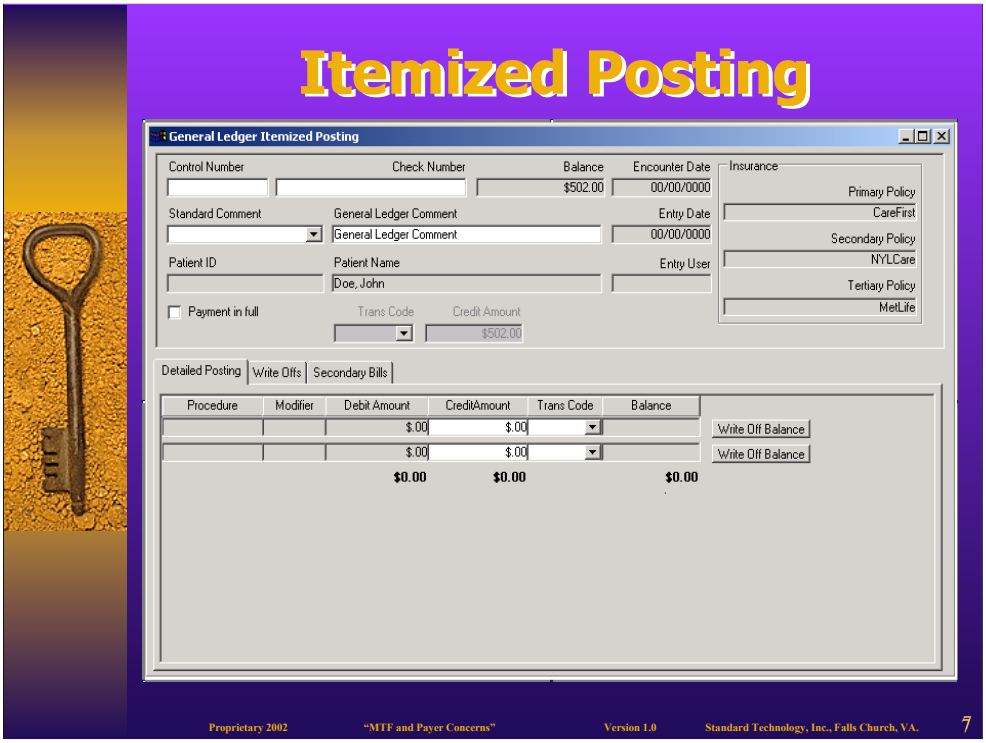
– **Duplicate billing:** This type of billing impacts payers greatly and leads to unnecessary claim backlogs thus, resulting in the delay of claims reimbursement.
  • Proper follow-up methods should be performed before submitting a duplicate claim.



- When Itemized Billing is implemented and line item charges are submitted to payers for payment:
  - Payers will send an Explanation of Benefits (EOB) or Remittance Advice that reflects **line item payments**.
  - It will be necessary to post payments in accordance with the line item detail submitted on the EOB.

- Itemized Posting will be simultaneously implemented as a TPOCS enhancement or will be retroactively applied to the implementation date of Itemized Billing.

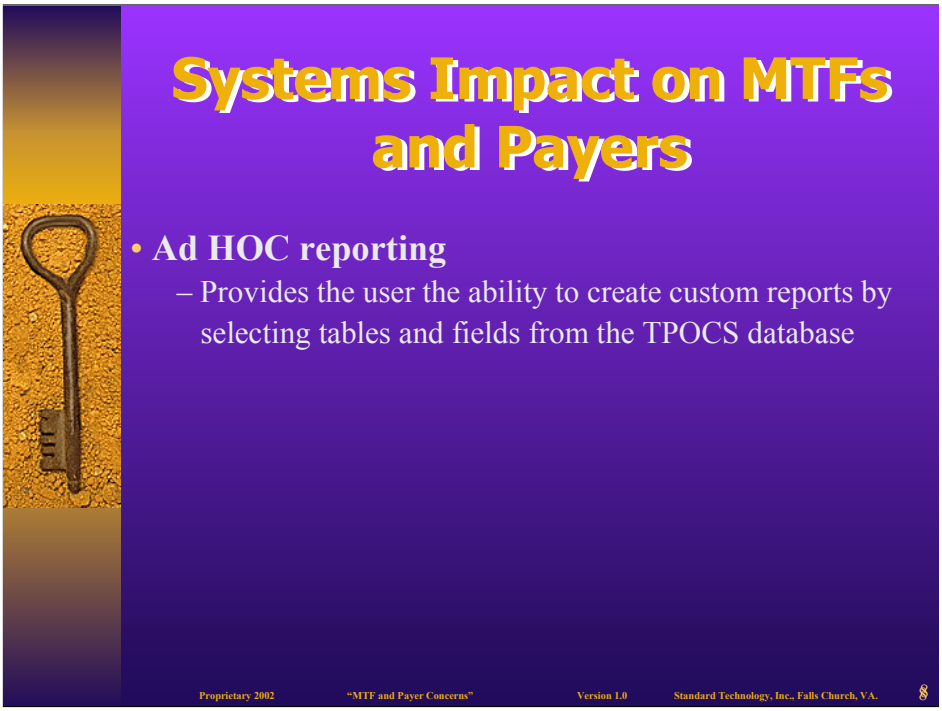
NOTE TO TRAINER: There is a sample civilian EOB provided for your review.



- Upon selection of a control number, the general ledger will be automatically populated with account details.
  - Note that the "grayed out" areas will not be editable
- When posting to an account, the user will:
  - Select the line item identified by the CPT-4/HCPCS code.
  - Post appropriate payment to each line item in accordance with the EOB.
  - Perform necessary actions for further follow-up or write-off.

Note: If payment received for entire claim is "Paid in Full," the system will auto-distribute payments to each line item.

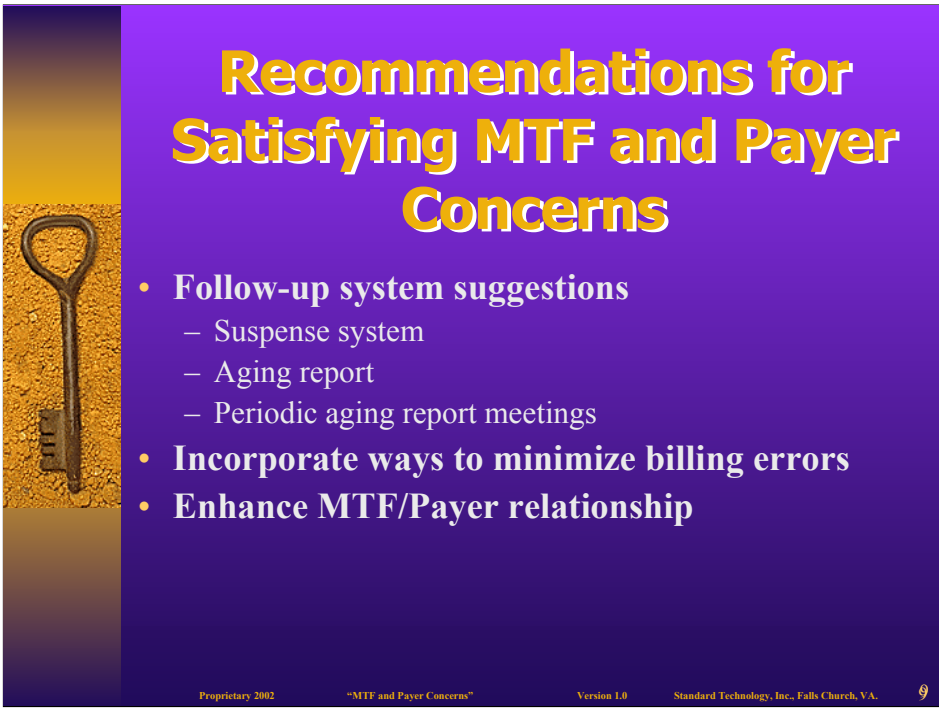
- Under the Itemized Posting methodology, batch posting will no longer be available.



- The user can create a customized report, save it for future use and share it with other TPOCS users.

- The Ad Hoc reporting process will be discussed in detail during systems training.

- Other Systems Impact on MTFs and Payers as indicated in the OIB Overview include:
  - Synchronization of TPOCS/CHCS Standard Insurance Table (SIT) and Other Health Insurance (OHI) table
  - Automation of pharmacy, laboratory and radiology data transfer
  - Addition of Universal Claim Form (UCF)
  - New Rate Tables
  - Accommodate Medical Services Account billing in CHCS
  - Secure and efficient Internet electronic billing capabilities



• **Follow-up system suggestions:**

– **Suspense system** – This system can be put in place to indicate the need for follow-up on a particular claim.

– **Aging report** – This report will identify the amount of time a claim has been listed as an account receivable.
– It can be created in the either the time or dollar amount method.

• **Time Method:** Can be divided into 30, 60, 90, 120, and 180 days past due intervals The claims with the oldest date of service should be focused on until resolved.
• **Dollar Amount Method:** This method can be implemented by listing the claims with the highest dollar amount, regardless of time past due.

– **Periodic aging report meetings** – Conduct periodic inter-departmental meetings to discuss past due claims and issues that MTFs are experiencing with identified payers.

• **Incorporate ways to minimize billing errors:**
– Consider bundling claims.
– Audit your claims.
– Notify various departments of their errors and track how they are improving.
– Consider using stamps to indicate re-submission of claims. (e.g., 2nd Submission, 3rd Submission, etc.)

• **MTF/Payer relationship:**
– Establish a relationship with the claims department and/or follow-up area of the top 10-15 payers.
– Get to know the claim processors of the payer.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10

Sample Civilian Sector Explanation Of Benefits (EOB)

Health Plan Name

Health Plan Street Name, City, State and Zip Code

Explanation of Benefits

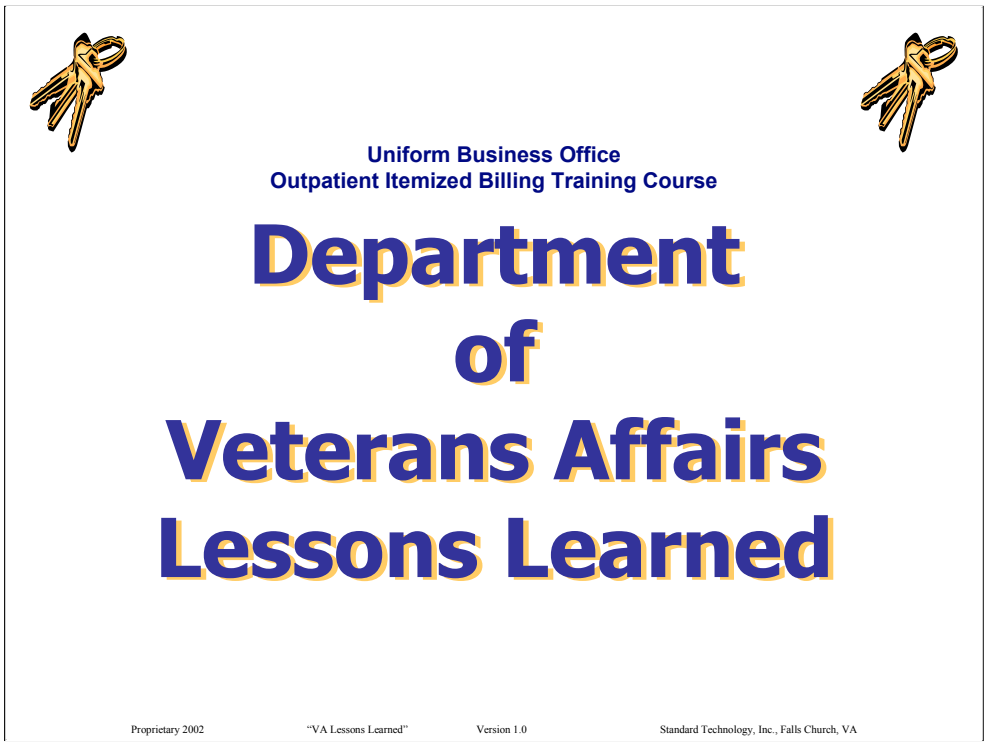
4/1/2002

(This is not a Bill)

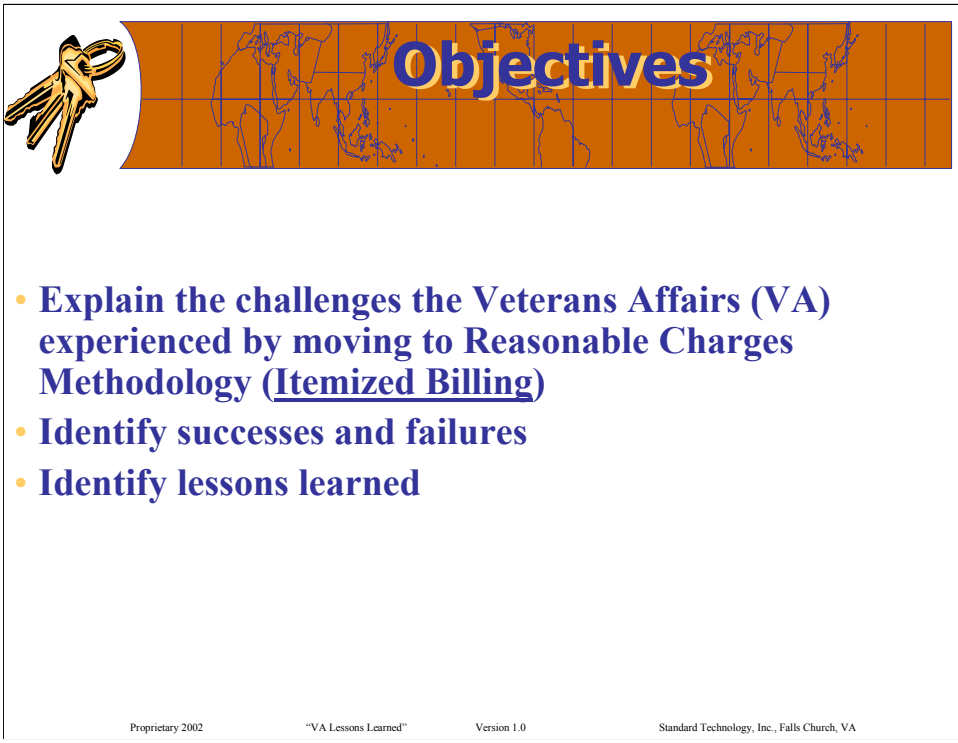
Subscriber:	Doe, John Sr.	**Patient Name:**	Doe, John Sr.
Address:	1234 Anywhere Street, Everywhere, US 00000	**Contract #:**	123456789
		Date of Service:	12/12/2001
		Claim Number:	40025761234
		DRG#:	N/A

Provider/Service	Amount Billed	Amount Denied	Rsn Code	Service Amount allowed	Medi Allowed	Medi Paid	Deductible/Copay/Coinsurance	Amount Paid
99214	$50.00	$0.00	PY	$50.00			$5.00	$50.00
97112	$116.00	$116.00	DC	$0.00				$0.00
97140	$76.00	$76.00	DC	$0.00				$0.00
97504	$70.00	$0.00	PY	$65.00				$65.00
Total:	$312.00	$192.00		$115.00			$5.00	$115.00

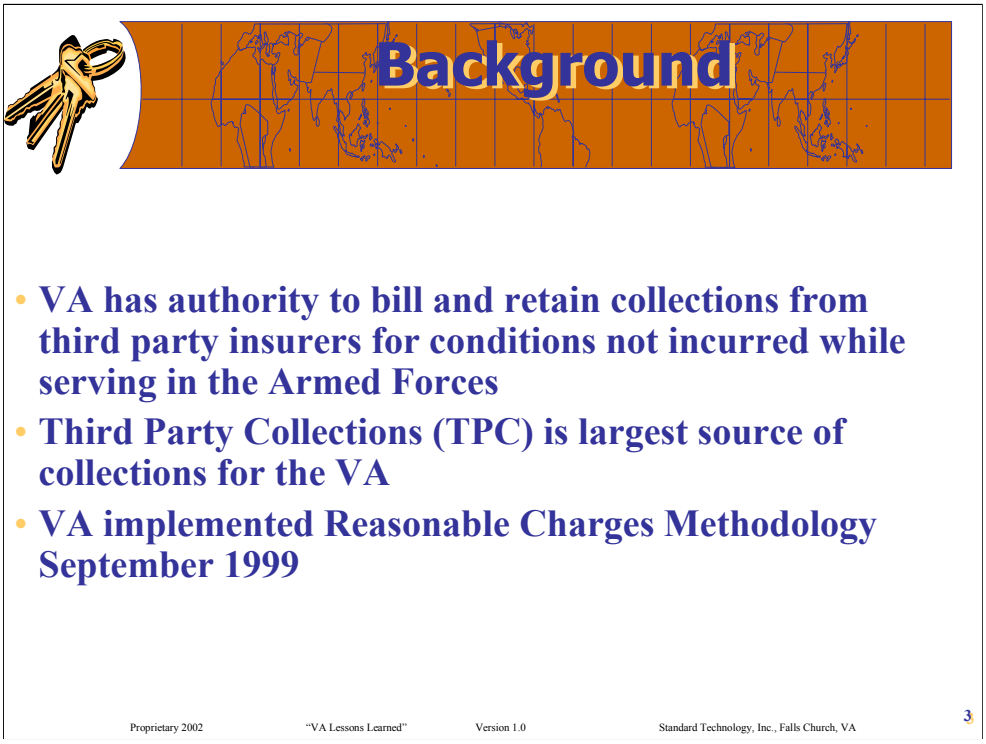
Rsn Codes	PY	Paid based on contractual allowed amount
	DC	Denied for additional medical documentation



Information used for this presentation was taken from testimony by the General Accounting Office (GAO) of the United States which was released on September 20, 2001.



- We thought that it would be useful to know about some of the challenges the VA experienced since the MTFs are about to embark on a similar transition.



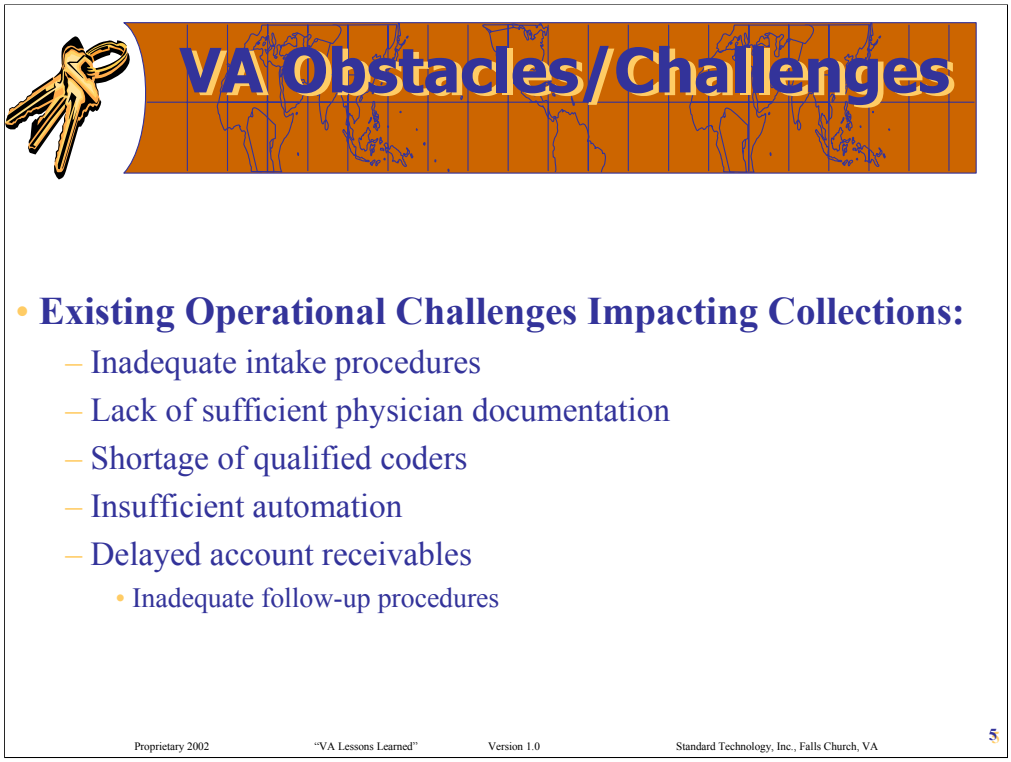
• The policy that supports the VA's Reasonable Charges (Itemized Billing):
  – *Public Law, 105-33 Balanced Budget Act of 1997*
  – Final regulations published April 27, 1999
  – Became effective September 1, 1999
  – The money collected is used to supplement its medical care appropriations.

• The National Defense Authorization Act of 2001 granted DoD the authority to move from reasonable cost to reasonable charges (Itemized Billing):
  – DoD is authorized to collect from third party payers the cost of medical care to DoD beneficiaries under Title 10 U.S.C. 1095.
  – Money collected is used to enhance patient care.

• For many years the VA had concerns about its ability to optimize its third party collections:
  – In January 1997 VA proposed a 5 year plan to operate with a flat annual appropriation of 17 billion dollars per year through F/Y 2002.
  – In 1998 a national VA review found many process inefficiencies and factors that caused the VA's potential collections to be limited.
  – In 1999 the VA submitted a business plan to Congress calling for an evaluation of two major alternatives for improving operations and collections.
    • Both alternatives called for each network to consolidate portions of revenue operations, but one alternative thought that using in-house staff was the way to achieve this while the other alternative was to outsource.
    • September 1999 VA implemented reasonable charges.
  – In F/Y 2000 as facilities adjusted to the new requirements under reasonable charges, collections initially decreased then slowly began to increase.
  – In F/Y 2001 the VA began to see a significant increase in collections.

VA Implementation

- **Outpatient Billing moved from one flat-rate to separate claims for:**
  - Physician charges
  - Outpatient facility charges
- **Inpatient Billing moved from nine rates to:**
  - Hundreds of diagnosis codes
  - Thousands of procedure codes



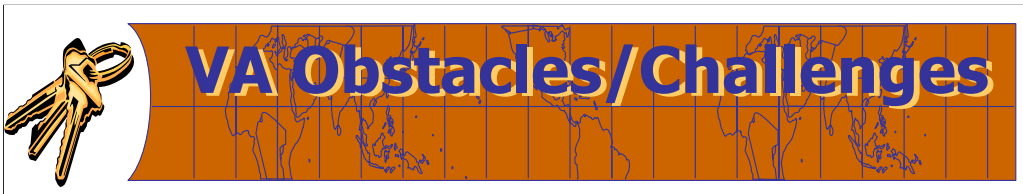
- VA is dependent on voluntary patient disclosure for billable insurance information or OHI (Other Health Insurance). This process has resulted in inadequate intake procedures:
  - Some patients will not disclose insurance information.
  - Only 16% of the insured veterans are being billed.

- Providers have concerns with time needed to document versus time available to care for patients:
  - The documentation was either incomplete or insufficient.

- The VA has a difficult time retaining a qualified coding staff at VA salary rates:
  - Primarily due to competition with other employers and the VA's low wages on entry level positions.
  - The VA had problems retaining and promoting proficient coders.

- VA information systems lack sufficient technological upgrades resulting in insufficient automation overall:
  - VA sponsored 2001 study of the possible uses of commercial software found limitations in VA's billing software that led to manual processes.
  - VA's process for creating bills and detecting errors is less automated than in the private sector.
  - Increased errors and slower production resulted in fewer collections for the VA.

- Majority of VA's account receivables exceed 90 days:
  - The VA believes insufficient follow-up is a reason for this.
  - Due to a lack of proper follow-up at one VA site, two staff members were trying to decrease a backlog of 3000 to 4000 unpaid claims, but they were unable to make more than 60 follow-up telephone calls per day.

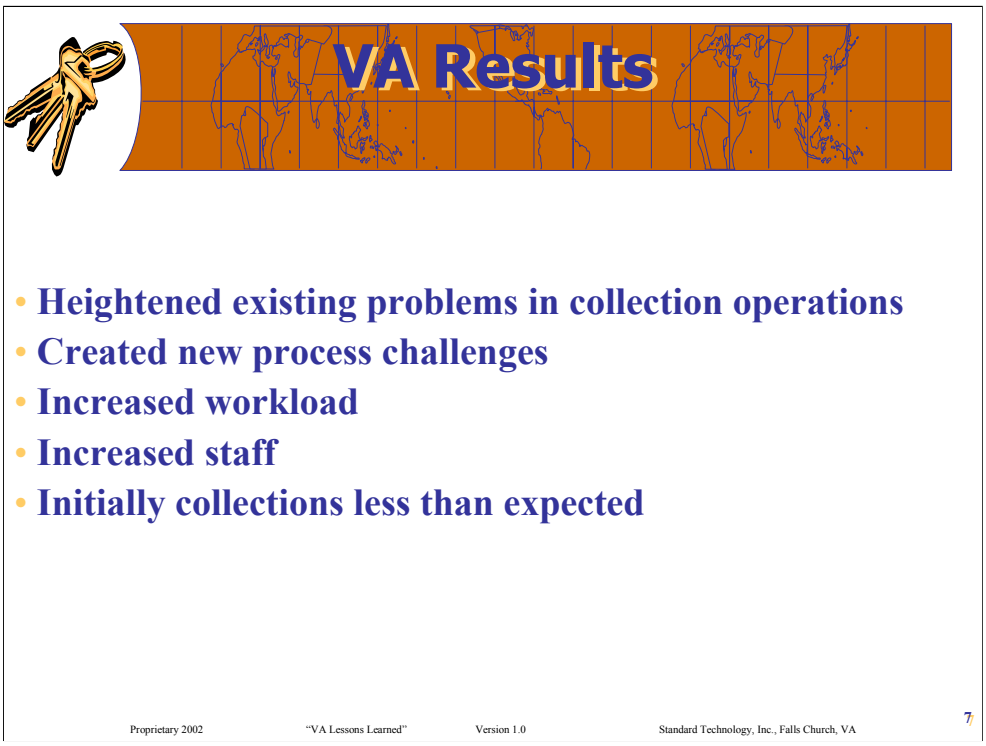


- Lack of department wide standardization highlights the weaknesses the VA has in managing and improving operations and collections nationally:
  - Lack of software and data standardization impaired the ability to measure performance.
  - No accurate way to measure findings from facility to facility.

- Due to the transition to Reasonable Charges Methodology, the number of bills increased approximately 5 times which added on to billing system frustrations:
  - Existing systems could not keep up.

- Business Practices vary widely from one VA facility to another due to a lack of decentralized responsibilities. There are no standard business practices from one facility to another nationwide:
  - (e.g. Electronic physician notes versus transcribing notes from dictation)
  - (e.g. It costs 5 to 15 cents for the top 25% of VA facilities to collect a dollar and it costs 31 to 64 cents for the bottom 25% of VA facilities to collect a dollar)
  - Delay in billing causing an average VA lag-time from date of service to date of billing for an outpatient visit is 143 days.
    - Average private sector lag-time from date of service to date of billing for and outpatient visit is 6 days.

- One auditing VA contractor estimated that nationally by administering co-signatures, the VA could collect more than $459 million if attending physicians co-signed the resident physicians' documentation.



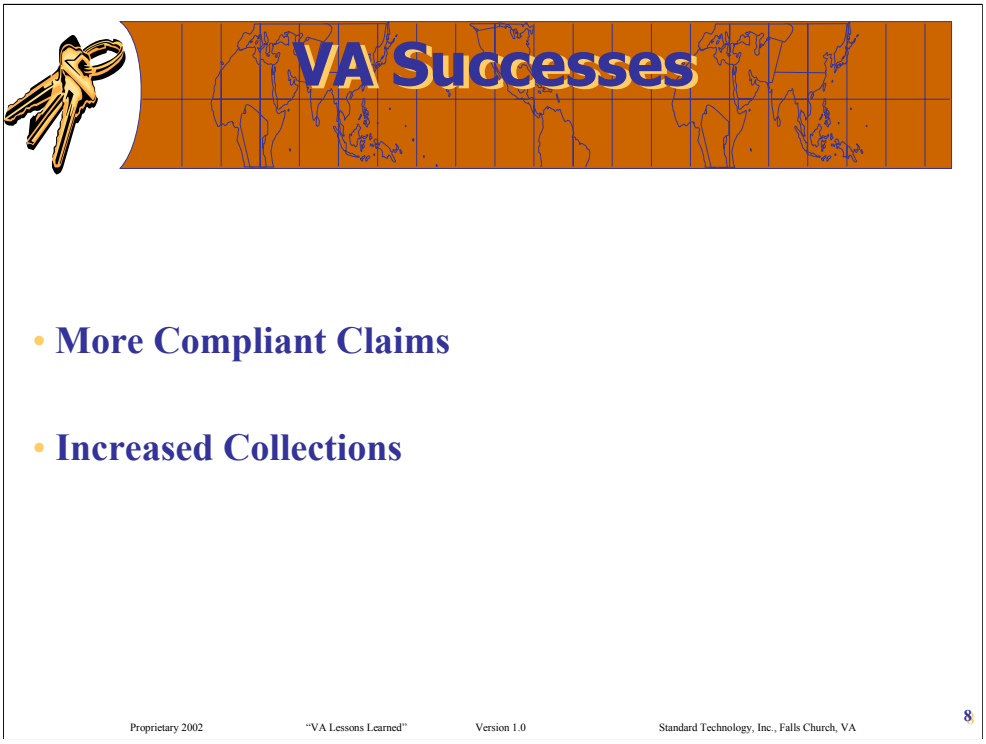
- Information systems and lack of department-wide standardization created weaknesses for managing and improving collection operations. Existing problems were highlighted for all to see.

- Challenges of the new reasonable charges include accurate coding and documentation.

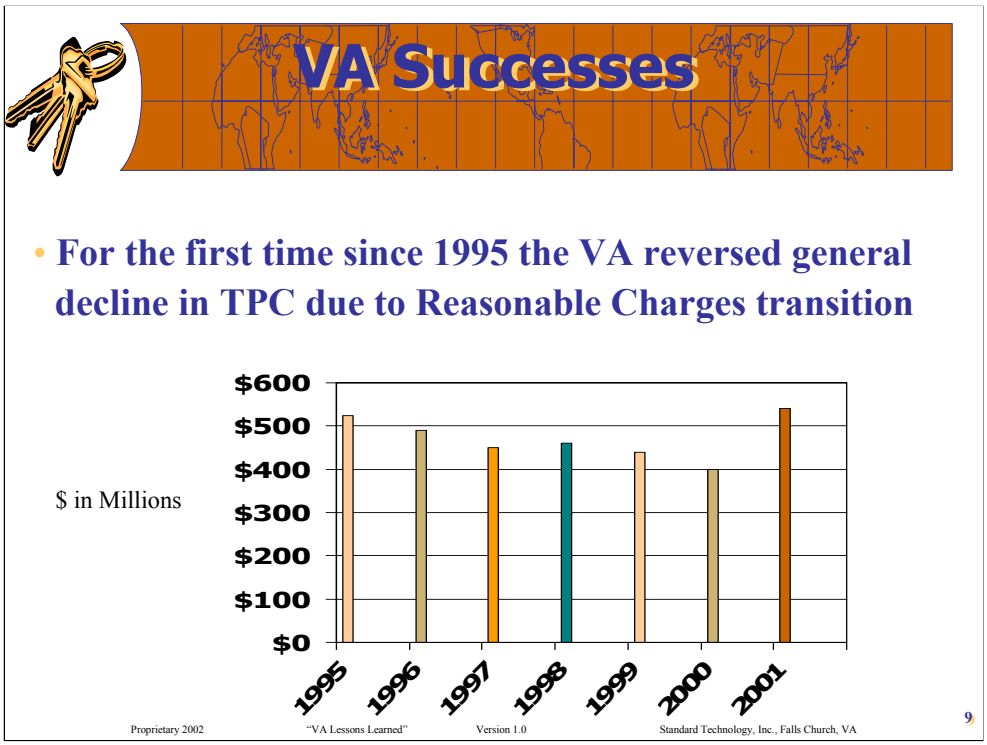
- The Reasonable Charges implementation has increased the number of bills approximately more than 5 times.

- All sites acquired more staff (both in-house and outsource):
  - (e.g., At one site, the staff of coders and billers increased from 7 to 19.)
  - Overall, based on 133 facilities surveyed, the full-time employees for collection operations increased from 2284 in FY 2000 to 2411 by the middle of FY 2001.

- At the time of this report the VA budget had only achieved 4% of the predicted 10% contribution from alternative sources due to non-authorization of Medicare payments by Congress.



- Claims are more compliant because now there's a charge for each line item.
- Increases in collections appear to be largely the result of the Reasonable Charges Billing Methodology.
- VA's new rates are higher than MTFs; therefore, the increase will be greater:
  - VA uses usual and customary rates as reasonable charges. These rates are based on market prices for services provided.

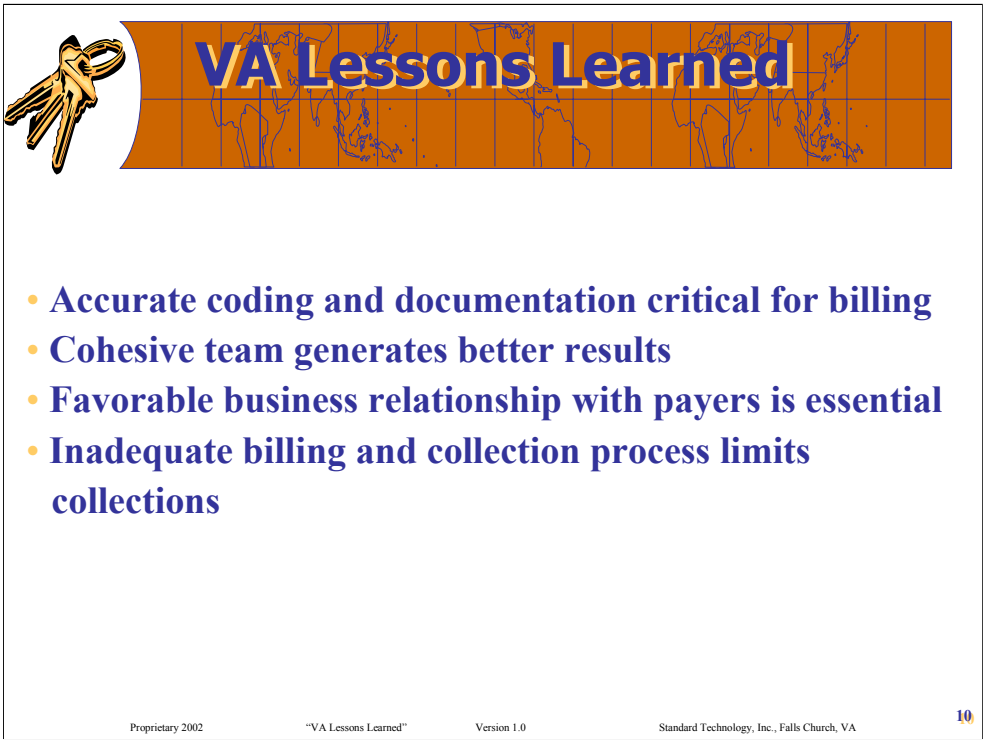


- Based on monthly collections for F/Y 2001 the VA collected $540 million from TPC compared to $523 million collected in F/Y 1995:
  - VA estimates that collections from alternative sources such as TPC will be about 4% of its medical care funding for F/Y 2002 or $896 million.

- The VA treated approximately the same number of patients in the first eight months of FY 2001:
  - Collected 34% more dollars than in a comparable period in FY 1999 (before Reasonable Charges were implemented).
  - If the VA collected 34% more collections with on-going problems, imagine what your facility can do by eliminating some of the problems the VA has already experienced.

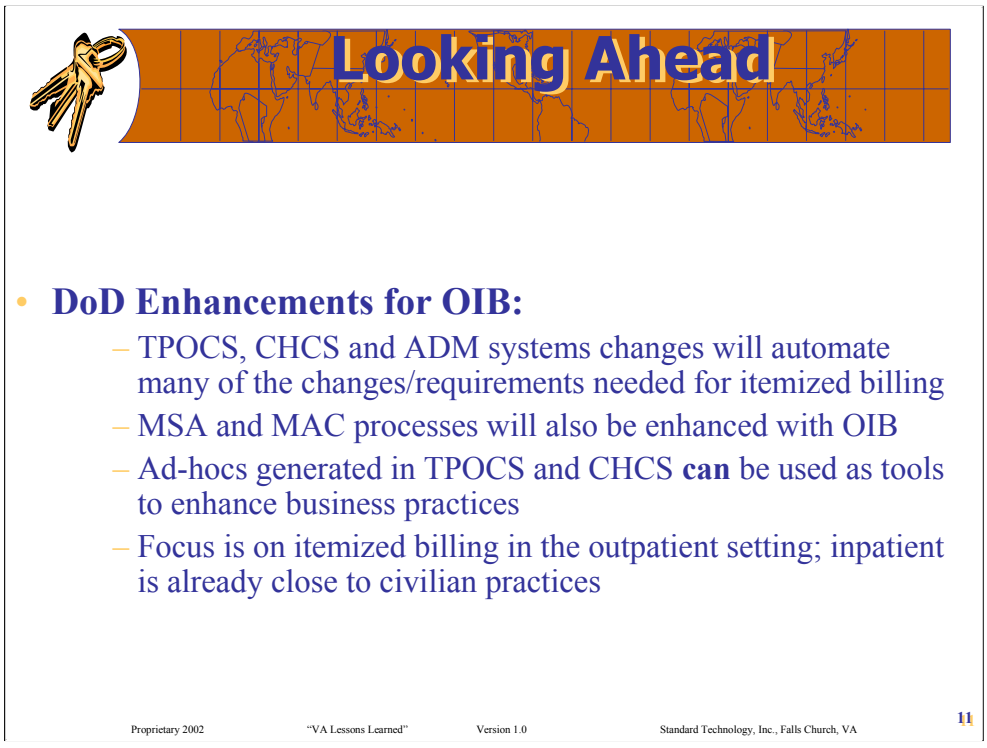
- As mentioned earlier in F/Y 2000 VA collections initially decreased as facilities adjusted to the new requirements under reasonable charges.

- VA began to realize a significant increase in collections in F/Y 2001.



- Hearing about the lessons learned by the VA may help your facility manage any problems or challenges that may arise:
  - Accurate coding and documentation affect all aspects of billing and collecting.
  - Approach major hurdles as a cohesive team to achieve maximum effectiveness.
  - Supply all necessary data and documentation to payers to expedite the processing of claims.

- Evaluate your current business practices:
  - Reorganize the weak areas of your business operations.
  - Make a difference in your facility.



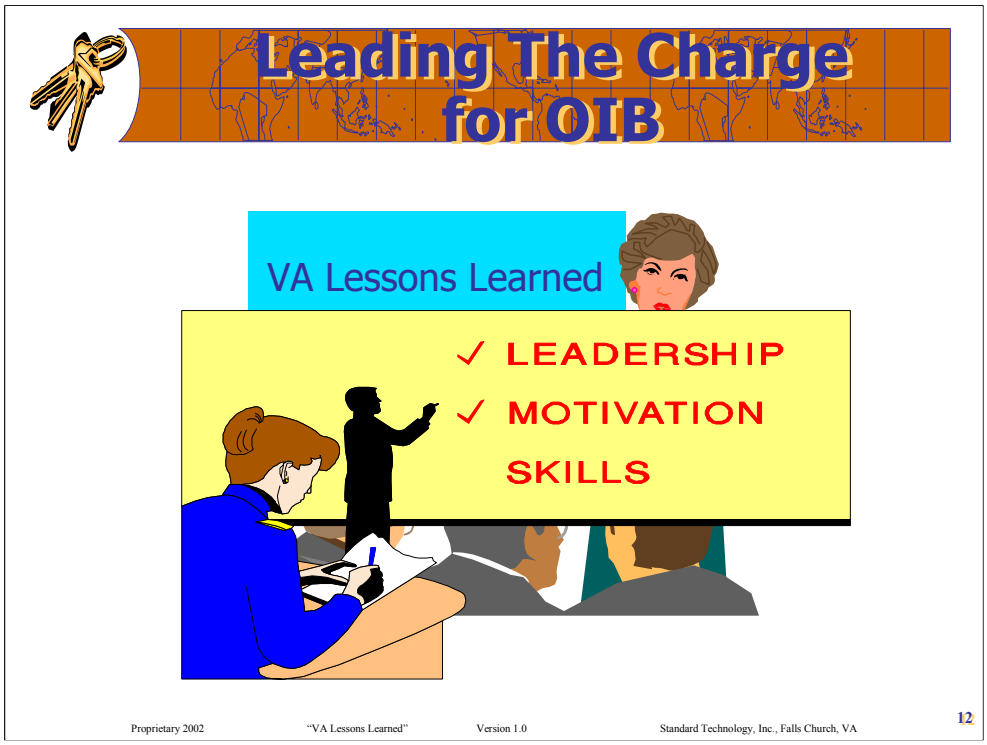
• Information was shared with you in the OIB Overview Presentation on how CHCS, ADM and TPOCS are being updated or designed in such a way that data will be linked from system to system enabling claims to be produced on the UB-92, CMS-1500, UCF and ADA claim forms.

• Information was also shared on how itemization will occur on form DD7A and the I&R for MSA claims and how itemization for MAC and MSA claims will occur when using the UB-92, CMS-1500, UCF, or ADA claims forms.

• Ad-hocs in both CHCS and TPOCS **can** enable users to create documents to meet specific needs. Ad-hocs **can be used** as a follow-up tool in TPOCS when trying to collect on account receivables.
  – (e.g., Generate an ad-hoc on 100 outstanding claims from the same payer utilizing all pertinent information that the payer would need to follow-up on the claims (e.g., name, account number, patient control number, date of service, amount billed etc.). Submit that list along with a cover letter to the payer requesting the status of all 100 claims. Request a response within 10 days of date of your cover letter. This process can be done within a few minutes compared to hours when done by telephone).

• The focus is on outpatient billing right now which provides a great opportunity to align the MTFs with the civilian sector as well as improve current billing practices. Changes on Inpatient Billing will be addressed at a later date.

• Please realize that the transition to OIB will bring on a myriad of feelings among all personnel. With hard work, dedication, team effort and the information shared with you on the lessons that the VA learned you and your staff will be headed towards a successful transition to OIB.



•**Note to Trainer:** After VA presentation has been presented ask the attendees to assume that they are responsible for helping their MTF get ready for OIB.

• Ask them (What potential challenges might your MTF face in preparation for OIB?)

• Allow attendees, while working individually for 3-4 minutes, to brainstorm on potential challenges they might face at their MTFs. Have them jot down their ideas on a sheet of paper.

• Ask for 2 or 3 volunteers to share some of their ideas with the other attendees. Jot the ideas on the board.

• **List of possible challenges:**
- Technology updates
- Better Wages
- Better in-take procedures
- Better documentation
- Outsourcing
- Enough Coders
- Business Process Re-engineering (BPR)

Are there any questions?

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KEYS TO CHANGE

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CHANGE MANAGEMENT OBJECTIVES

- Discuss human reactions to change
- Suggest ways to provide team involvement and visionary leadership for change

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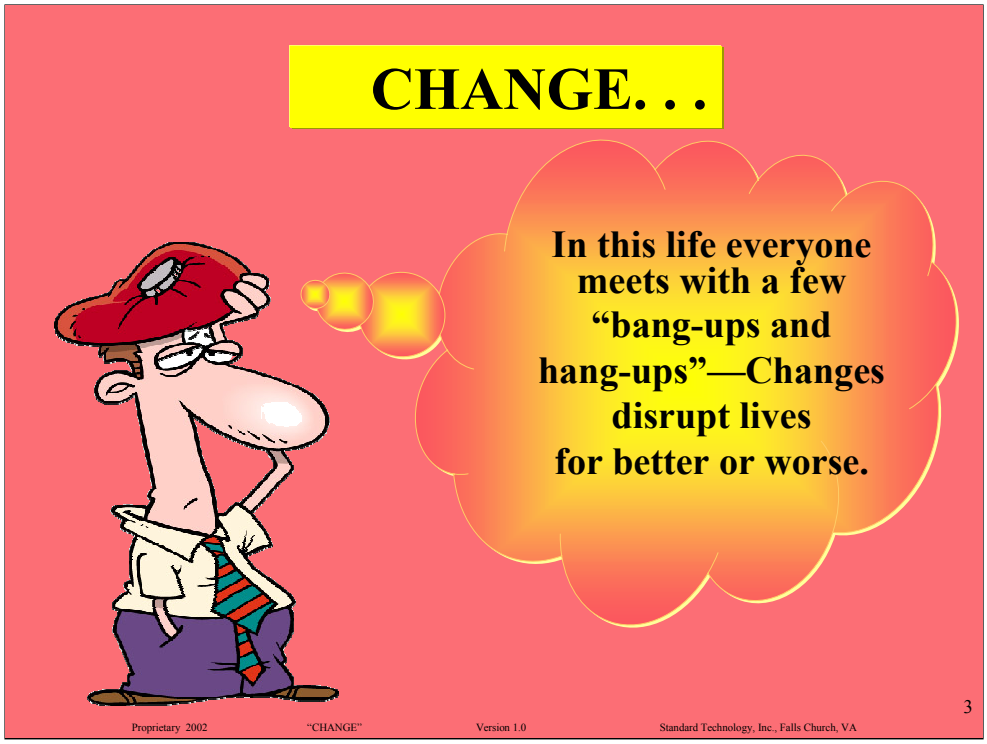
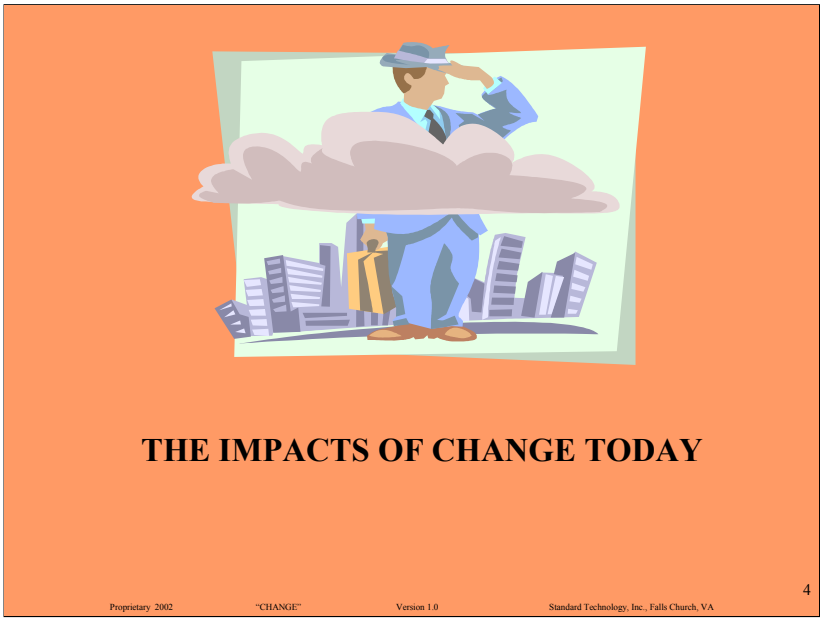


- If you try to ignore the situation, change will bump into you and knock you off balance.

- Getting angry about change won't make it go away - it's a normal reaction and expectation.

- Things are changing rapidly. The odds are that you will probably be expected to get more done, maybe with fewer resources and in a shorter period of time.

- Is that fair or reasonable? It doesn't matter! You may be upset, confused, or anxious, but you still have to deal with change and deliver results.



- So what does this mean for us?
  - Every employee will have to take greater responsibility for his or her part in organizational change and work continuously to improve new OIB knowledge and skills.

  - Change starts within each of us first. The most valuable employees will be the ones with the flexibility to master and accept the challenges of OIB.

  - Information will have to be broadly shared because more individuals will need it. Communication is key.

  - Assess the "change readiness" of your team. Are they ready to undertake a change? Don't make additional changes that aren't critical. People need all the stability they can get during change. Change the most important things one at a time.

- Be specific about personal accountability:
  - What needs to be done
  - Timelines/Deadlines
  - How to handle questions or make decisions
  - Report outcomes, etc

- Help team members understand that their job has a domino effect on other sections and/or departments.

• Be ready to provide some recommendations or input to MTF personnel at all levels in performing the following tasks:

- Help staff or co-workers with directions or training.
- Redesign duties and assignments in more specific terms for OIB.
- Establish definite deadlines and timetables regarding when work should be completed and changes put into place.
- Help staff or co-workers stay focused to avoid drop-offs in productivity.

- Whenever you ask people to do things differently, you disrupt their habitual way of doing things.
- This makes all of us feel uncomfortable, awkward, clumsy and ill-at-ease as we struggle to eliminate the old and learn the new.
- One of our biggest fears is that we will be embarrassed by our inadequacy in front of our peers. Everyone wants to do their jobs correctly.

FUNDAMENTAL PRINCIPLES OF MANAGING CHANGE

People going through the stages of change may progress, regress and then progress again many times

People may go through several different change processes (related to different changes simultaneously)

People are at different levels of readiness for change

It is possible to become stuck in one stage or to attempt to move out of a stage prematurely

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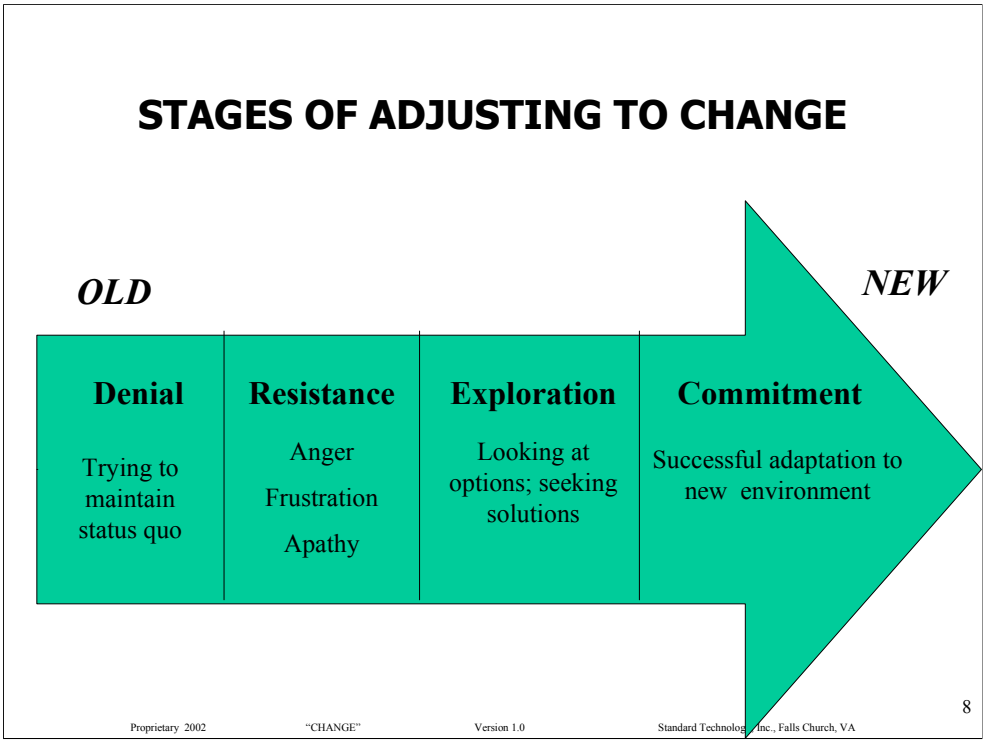
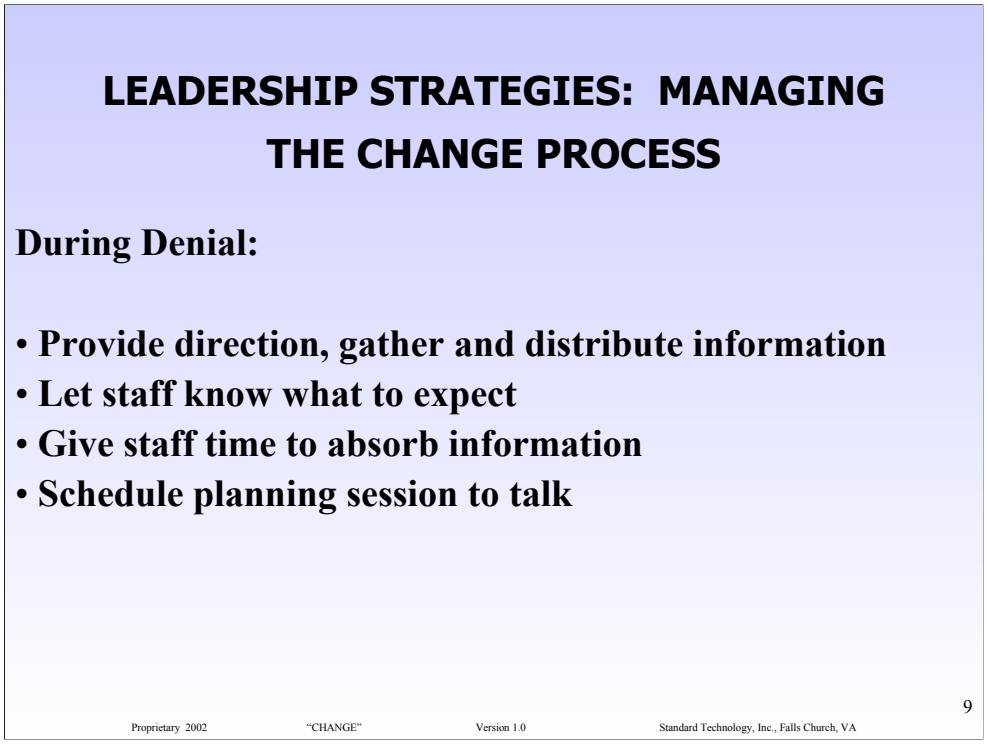


- It isn't the changes that make it difficult for people; it's the transitions.
- Change is not the same as transition.
  - *Change* is situational: it's the new equipment, the new team leader, and the new business procedures. Change occurs when something ends and something new or different starts.
  - *Transition* is the psychological process people go through to come to terms with the new situation. It's the period between the ending and beginning of something.



- During the denial phase, provide information in as many different forms as possible:
  - Group Meetings
  - One-on-One Discussions
  - Posters, Team Newsletters, Bulletin Boards

- Explain what is happening, what must be done and the rationale behind the changes.

- The stage of denial can be prolonged if employees are not encouraged or allowed to express their concerns.

MANAGING THE CHANGE PROCESS

During Resistance:

- **Provide empathy and support**
- **Be a sounding board--listen to and acknowledge people's feelings and concerns**
- **Encourage people to vent constructively**
- **Communicate objectively**
- **Acknowledge or reward progress**

10

- Resistance occurs when people have moved through denial and begin to experience self-doubt, depression, anxiety, frustration, fear or uncertainty because of the change.

- In the resistance phase, productivity can dip drastically.

- Acknowledge accomplishments through:
  - Symbols that demonstrate commitment to a new course of action or endeavor--pins, buttons, posters, slogans, etc
  - Praise work that has been done

MANAGING THE CHANGE PROCESS

During Exploration:

- **Channel energy into positive directions**
- **Provide information and referrals**
- **Encourage, support brainstorming and strategy sessions**
- **Facilitate networking and gather resources**
- **Provide positive feedback or constructive criticism**

11

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- During the exploration phase, energy is released as people focus their attention on the future and toward the external environment once again.
- Another word for this phase is chaos.
- Help teammates focus on priorities and provide any on the spot guidance.
- Follow-up on projects underway. Set short term goals. Conduct brainstorming, visioning and planning sessions.

MANAGING THE CHANGE PROCESS

During Commitment:

- **Set long-term goals**
- **Concentrate on team building**
- **Look ahead to the future**

12

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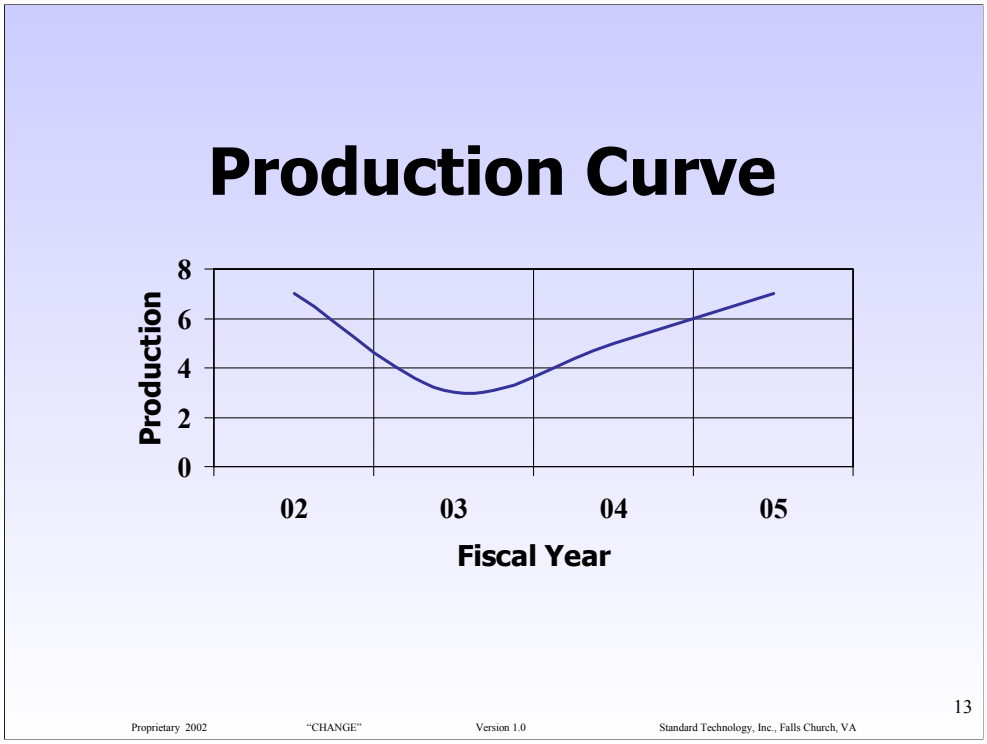
- During the commitment phase, employees are ready to focus on a plan.
- Commitment occurs when employees begin working together as a team toward a common goal.

NOTE TO TRAINER: Do "Assessing your team's readiness for change" activity.



- A learning curve is inevitable
- Things will get worse before they get better

Note: Read …

"CHANGE MANAGEMENT CLOSING"

ASSESSING YOUR MTF TEAM'S READINESS FOR CHANGE

Think about the 4 stages of change that people move through during a transition. List a few names of key team members from your MTF. Based on the indicators mentioned, make a guess about what stage each team member is at for accepting Outpatient Itemized Billing.

Name	Signs Observed	Phase

From the information presented and from your analysis, what approaches do you need to use and/or suggest to bring your MTF team members to the next level?

Who are the leaders within your MTF team that can help move others along?

Within your MTF team, which team members may need special help, training, or encouragement to help them more readily accept the change to OIB?

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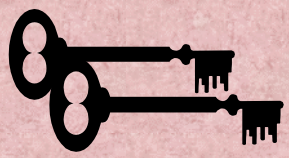
KEYS TO IMPLEMENTING OIB AT YOUR MTF



Objective

- Provide practical tips and tools to help you plan implementation of OIB at your facility

"Planning is everything-- and ongoing!"

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3

- Planning and managing the implementation of new method of doing business like OIB is essential.
- This planning and managing enables you to focus on priorities, track performances, overcome difficulties and adapt to change.
- It gives you more control and provides proven tools and techniques to help you lead teams to reach objectives on time and within budget.

Creating your implementation plan

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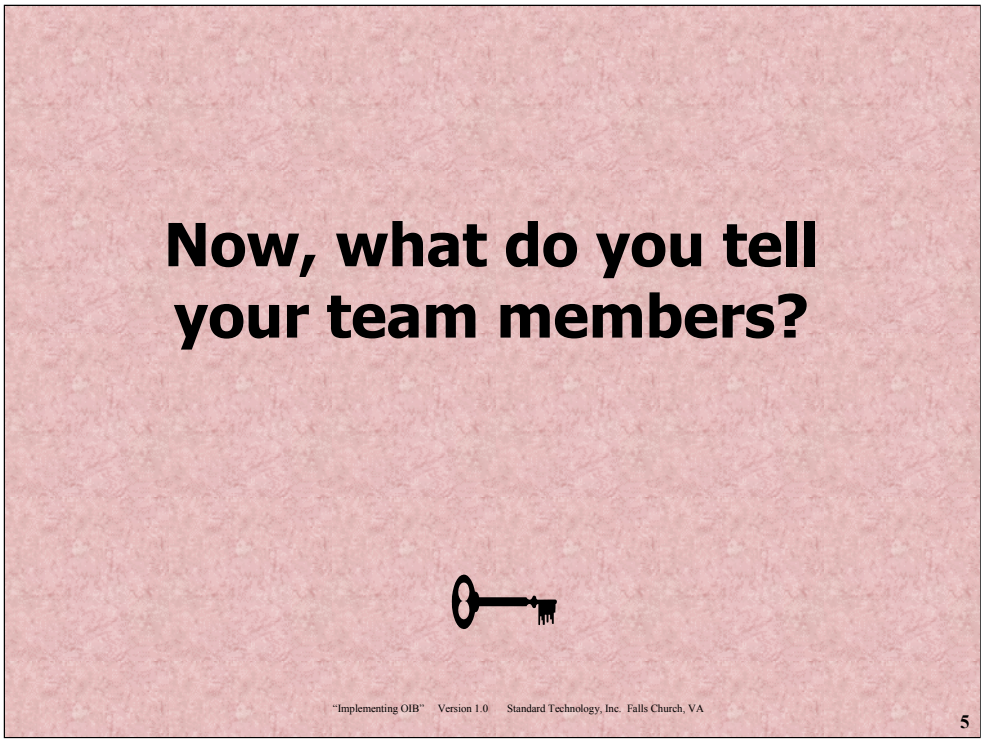
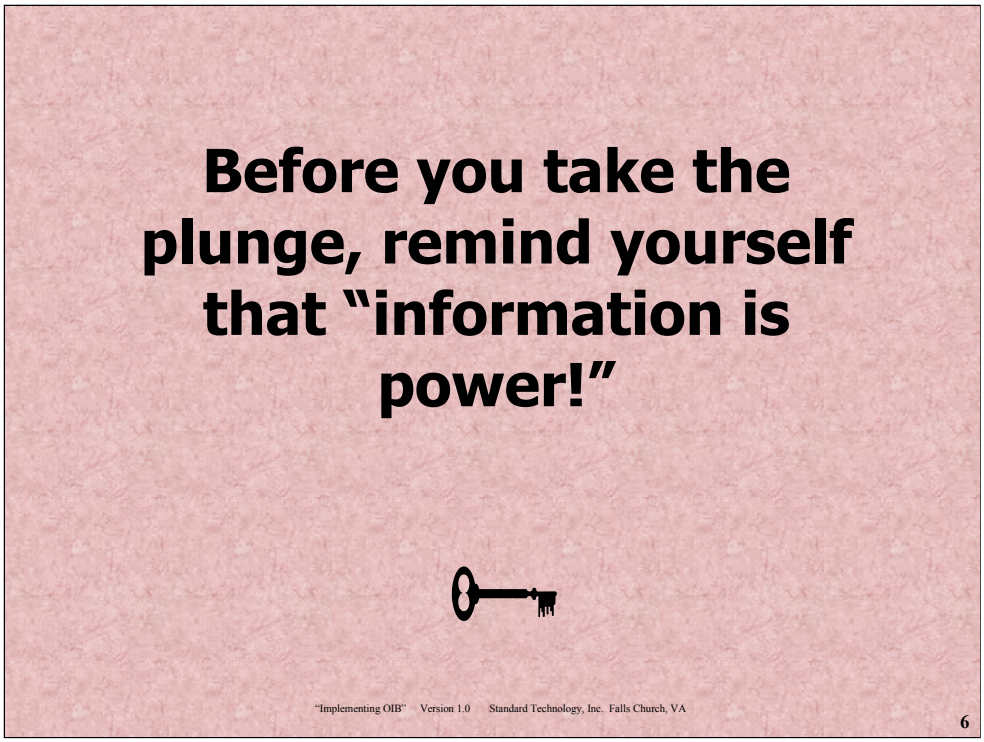
4

- Your implementation plan is created by you and your "Change Management Team" members.
- Your plan is really a set of related, interdependent action items that need to be accomplished to implement your change.
- The plan contains those technical action items that we logically know must be done, such as budgets, time tables and training.
- The plan also contains those human side action items that must be done to support the change, such as communication, culture and recognition and appraisal of team members efforts.
- Remember that the success of your change really depends on the detail planning and commitment of your team members.



- First impressions set the stage for everything that follows--and are often the most lasting ones.
- The "kickoff meeting" becomes an important occasion when you set a new direction for your employees.
- Now is your time to inspire employees and begin building their commitment to the change to OIB, as well as demonstrating your own firm commitment.
- Throughout the entire "kickoff meeting" you need to repeat what the changes are and the reasons for making them.
- By the end of the meeting, very few team members should walk out of the room unsure or misinformed about what was said

NOTE TO TRAINER: Have participants turn to "Facilitating Your OIB Kick-Off Meeting" handout and tell them to use this as a reference tool to plan their own kick-off meeting.



- Before you jump into the reality of implementing OIB, stop for just a moment.
- Remind yourself that "information is power." And, the more you know and plan for implementation, the more successfully you can manage it.
- Also, remember that while this change to OIB is about losses and endings, it's also about gains and new beginnings.

NOTE TO TRAINER: Have participants turn to handout "Getting Ready for Outpatient Itemized Billing" checklist. This should be used as a brainstorming tool to begin planning for OIB.

Have participants turn to handout "Action Plan Worksheet." This is to be done individually. Allow about 5-10 minutes for them to get started and they can finish back at their MTFs. Again, it is a preplanning document.

Action Plan Activities

Steps for Implementing OIB

Identify Areas For Improvement

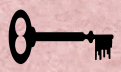
- Identify areas of bottlenecks & ways to improve:
  - Registration
  - Medical records coding
  - Collecting OHI data
  - Claims follow-up
  - Backlog of unprocessed claims
  - ADM interface issues
  - Mailing processes for non-electronic claims

Prioritize Areas For Improvement

- Determine which areas to tackle first
- Start with biggest problems
- Choose those with greatest return on investment

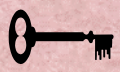
Defining Goals

- Goals should be focused, specific, and measurable
- Make sure goals are realistic
- Goals should be divided into achievable tasks
- Make sure employees understand what is to be achieved
- Expect to revise and enhance your goals



Develop A Plan Of Action

- Identify each task that needs to be completed to achieve goal
- Define interim milestones
- Assign deadlines to each task



Performance Measures

- Use DD 2570 Benchmarks/Metrics
  - Observed OHI rate (# claims / # dispositions)
  - Collected to billed ratio ($ collected / $ billed)
- Other Benchmarks/Metrics
  - Cost to collection ratio (MEPRS Code EBH / Total Collections)
  - Net revenue (Total Collections - MEPRS Code EBH)

- Performance measures should accurately reflect progress of goals.

Sample Benchmarks

- Aging from service date
  - A/R has 20% or less over 90 days
- Days from service date to claims filed date
  - 20-30 days outpatient
- Biller Productivity
  - Target 300-400 bills per day - paper claims
  - Target 400-500 bills per day - electronic claims

- Benchmarks are helpful to know where an MTF has been, where it is presently, and where it plans to go in the future. Measurement of satisfaction factors is also possible.

- Benchmarking processes enable MTF's to demonstrate that improvement activities are working.

Track Progress

- Visibly track progress toward goals
  - Exhibit graphs displaying progress
  - Publish articles in newsletters

- Visibly tracking progress not only informs people of the progress that has been made, it can also help motivate staff to achieve goals.

- Staff members must be given full responsibility for their jobs, and be empowered to execute and improve their work in ways that optimize their contribution to OIB. Don't micromanage.

- In sharing responsibilities, all departments and staff must be responsible for implementing new OIB policies, monitoring progress, and responding creatively and constructively where action falls short of objectives and goals.

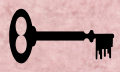
- To ensure peak performance, all members must be aware of their responsibilities and how their work impacts OIB.

- Show flexibility by sharing aspects of your knowledge with OIB and help other staff members understand the changes that must occur for OIB to be successful.

- The desired outcomes of OIB are to optimize cost recovery (net revenues) to enhance healthcare, improve compliance, and improve internal and external customer satisfaction.

It's the constant and determined effort that breaks down all resistance and sweeps away all obstacles!

--Author Unknown



GETTING READY FOR OUTPATIENT ITEMIZED BILLING

I. PREPLANNING FOR IMPLEMENTATION

A. Resources

1. Whose input/support do we need?

- ❒ MTF Commander
- ❒ UBO Service Manager
- ❒ UBO Manager
- ❒ Resource Management
- ❒ Division Chiefs/Managers
- ❒ Information Management
- ❒ Risk Management/Quality Assurance
- ❒ Providers
- ❒ Clinical Staff
- ❒ Federal Employee Unions
- ❒ TPC Staff
- ❒ Patient Administration
- ❒ Health Information Management/Medical Records (Coders)
- ❒ Others_____

- ❒ How do we obtain the above input/support?

2. What resources do we need?

- ❒ Hardware upgrades/purchases
  - □□ Computers
  - □□ Monitors
  - □□ Printers
  - □□ Server Upgrades
  - □□ Telephones
  - □□ Modems
  - □□ Photocopiers
  - □□ Wiring
  - □□ Maintenance agreements

- ❒ Software upgrades/purchases

- ❒ Supplies
  - □□ Reference Materials/Manuals
  - □□ UBO Policies & Reference Materials for Coding & Billing found at:

    http://www.tricare.osd.mil/ebc/rm_home/imcp/ubo/ubo_09.htm

  - □□ New/unique supplies
    - Forms
    - Others_____
  - □□ Identify vendors/suppliers
- ❒ Training for staff
  - □□ Who should be trained?
  - □□ What are training topics?
  - □□ How should training be delivered? By whom?
  - □□ What training materials are needed?
- ❒ Security measures
  - □ Business Office
  - □□ HIM/Medical Records
  - □□ Hardware/software
  - □□ Who has access permission?
  - □□ HIPAA Compliance to ensure privacy & security
- ❒ Additional facility space needed? If so, for whom? How much?
- ❒ Additional staff needed? If so, who? How many?
  - □□ _____
  - □□ _____
  - □□ _____
  - □□ _____

  - □ Do we hire or outsource?
  - □□ What special skills/knowledge will be needed?
  - □□ What specific training will be needed for new/contract staff?
  - □□ When should new/contract staff be employed?
  - □□ Recruitment methods
- ❒ Special contracting costs?
- ❒ Others_____

3. What resources do we have available?

- ❒ _____
- ❒ _____
- ❒ _____
- ❒ _____
- ❒ _____

4. What successes/mistakes can we learn from?

- ❒ VA Lessons Learned –Tips & Reminders
- ❒ _____
- ❒ _____
- ❒ _____

B. Administrative Issues

1. Who is the "champion" for implementation? _____

2. What limitations will we have with implementation?

3. What risks will we face with implementation?

4. How will we continue to run day-to-day operations during implementation?

5. Who will have oversight authority for transition/implementation?

6. What are lines/flow of communication for implementation?
   - □□ For full-time staff
   - □□ For part-time staff
   - □□ For team leads & supervisors

7. What will be methods of reporting?

- ❒ Frequency
  - □□ Weekly
  - □□ Monthly
- ❒ Type
  - □□ Written reports
  - □□ E-mails
  - □□ Memos
  - □□ Telephone
  - □□ Team/departmental meetings
- ❒ Distribution structure (who needs to receive information)?
- ❒ What information should be distributed?

8. What structures do we need?

- ❒ Staff training plan
- ❒ Evaluation of hardware/software
- ❒ Methods to complete backlog of existing work
- ❒ Compliance program
- ❒ Current work flow/work load review & evaluation
  - □□ Reassignment of jobs/tasks/duties
  - □□ Development of new roles & responsibilities
  - □□ New/updated job descriptions written
- ❒ Methods for creating change/business process reengineering (BPR)
- ❒ Methods for promoting OIB to all stakeholders
  - □□ MTF commander
  - □□ All MTF staff
  - □□ Patients
  - □□ Payers
- ❒ New operational business rules
  - □□ New policies to be implemented
  - □□ New procedures to be implemented
  - □□ Current policies/procedures to be deleted or changed
    - □□ Collections Operation Processes
      - □□ Patient intake
      - □□ Medical documentation
      - □□ Coding
      - □□ Billing

- Accounts Receivable
- Posting payments
- Reporting

- New rules/regulations

- ❒ Change Management Plan

C. Finances

1. Estimation of implementation costs _____

2. How readily available will TPC funds be for proposed changes?

3. How will additional required monies be obtained for implementation?

D. Operations

1. What is timeline for implementation?

2. What issues may impact date of implementation?

3. What are initial implementation milestones?

4. What are initial goals of implementation?

E. Monitoring Quality

1. How will we monitor our progress?

2. How will we know we are on course?

3. How will be track differences between what was planned & what is happening?

4. What are the milestones? By when?
   - ❒ Reduction of errors ___%
   - ❒ Increase in collection ___%
   - ❒ Improvement in productivity ___%
   - ❒ Collection of patient OHI data ___%

5. Is satisfaction of results by stakeholders being met? If not, why?
   - ❒ Patients
   - ❒ Providers
   - ❒ MTF Staff
   - ❒ TPC Staff
   - ❒ Payers

6. Are resource requirements matching actual utilization?

7. Are gaps or overlaps in plans & processes being monitored in processes?

F. Public Relations

❒ What methods will be used to promote/advertise OIB?
- To patients
- To MTF staff
- To payers
- To others_____

II. IMPLEMENTING A PLAN

A. Building a Team

1. Will teambuilding activities be needed?

2. How will we maintain positive morale?

3. How will we recognize staff successes?

4. What organizational culture issues must be considered?

   - ❒ Dealing with staff conflicts
   - ❒ Managing negative attitudes/resistance
   - ❒ Helping staff through change management process
   - ❒ Handling grievances
   - ❒ Retaining good employees

B. Organizing Ongoing Implementation Meetings/Activities

- ❒ How can we become more effective/productive?
- ❒ What obstacles are preventing change?
- ❒ What new/additional training is needed? For whom? By when?
- ❒ How can we promote our successes?

- ❒ What methods/processes are not working well? How can they be improved?
- ❒ What methods/processes are working particularly well?
- ❒ How can we improve stakeholders' participation?
  - Senior administration/management
  - Physicians/Clinicians
  - Billers
  - Coders
  - Other MTF staff
  - Patients
  - Others_____

- ❒ What are new goals/milestones?
- ❒ What are new timelines?
- ❒ How can we improve quality/accountability?
- ❒ What additional research is needed?
- ❒ What additional supplies/equipment/staff is needed?

Glossary and Definitions

The following information has been excerpted from the "Department Of Defense Glossary Of Healthcare Terminology" (DoD 6015.1-M).

ABUSE. A pattern of improper or excessive use or treatment.

ADA. American Dental Association.

ADDITIONAL DIAGNOSIS. Any diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the physician considers of sufficient significance to warrant inclusion for investigative medical studies.

ADMISSION. The act of placing an individual under treatment or observation in a medical center or hospital. The day of admission is the day when the medical center or hospital makes a formal acceptance (assignment of a register number) of the patient who is to be provided with room, board and continuous nursing service in an area of the hospital where patients normally stay at least overnight. When reporting admission data always exclude: total absent-sick patients, carded-for-record only (CRO) cases and transient patients.

ADMITTING DIAGNOSIS. The immediate condition that caused the patient's admission to the MTF for the current, uninterrupted period of hospitalization.

ADM. Ambulatory Data System.

ANCILLARY. Tests and procedures ordered by healthcare providers to assist in patient diagnosis or treatment (radiology, laboratory, pathology, etc.).

APV. Ambulatory Patient Visit. Refers to immediate (day of procedure), pre-procedure and immediate post-procedure care in an ambulatory setting. Care is required in the facility for less than 24 hours.

ASSIGNMENT OF BENEFITS. The payment of medical benefits directly to a provider of care rather than to a member. Generally requires either a contract between the health plan and the provider or a written release from the subscriber to the provider allowing the provider to bill the health plan.

ATTENDING PHYSICIAN. The physician with defined clinical privileges that has the primary responsibility for diagnosis and treatment of the patient. A physician with privileges to practice the specialty independently. The physician may have either primary or consulting responsibilities depending on the case. There will always be only one primary physician; however, under very extraordinary circumstances, because of the presence of complex, serious and multiple, but related, medical conditions, a patient may have more than one attending physician providing treatment at the same time.

BALANCE BILLING. The practice of a provider billing a patient for all charges not paid for by the insurance plan, even if those charges are above the plan's UCR or are considered medically unnecessary. Managed care plans and service plans generally prohibit providers from balance billing except for allowed copays, coinsurance, and deductibles. Such prohibition against balance billing may even extend to the plan's failure to pay at all (e.g., because of bankruptcy).

BPR. Business Process Reengineering. MHS Business Process Reengineering is a radical improvement approach that critically rethinks and redesigns product and service processes within a political environment to achieve dramatic MHS mission performance gains.

BUNDLING. Combining into one payment the charges for various medical services rendered during one health care encounter. Bundling often combines the payment from physician and hospital services into one reimbursement. Also called "package pricing."

CFR. Code of Federal Regulations.

CHCS. Composite Health Care System. Medical AIS that provides patient facility data management and communications capabilities. Specific areas supported include MTF health care (administration and care delivery), patient care process (integrates support--data collections and one-time entry at source), ad hoc reporting, patient registration, admission, disposition, and transfer, inpatient activity documentation, outpatient administrative data, appointment scheduling and coordination (clinics, providers, nurses and patients), laboratory orders (verifies and processes), drug and lab test interaction, quality control and test reports, radiology orders (verifies and processes), radiology test result identification, medication order processing (inpatient and outpatient), medicine inventory, inpatient diet orders, patient nutritional status data, clinical dietetics administration, nursing, order-entry, eligibility verification, provider registration and the Managed Care Program.

CHCS II. Composite Health Care System II

CHANGE MANAGEMENT. It is the process of facilitating change to current business operations and the assessment of an organization's readiness and acceptance towards the transition.

CLAIM. Any request for payment for services rendered related to care and treatment of a disease or injury that is received from a beneficiary, a beneficiary's representative, or an in-system or out-of-system provider by a CHAMPUS FI/Contractor on any CHAMPUS-approved claim form or approved electronic media. Types of claims and/or data records include Institutional, Inpatient Professional Services, Outpatient Professional Services (Ambulatory), Drug, Dental and Program for the Handicapped.

CLAIM REIMBURSEMENT. The payment of the expenses actually incurred as a result of an accident or sickness, but not to exceed any amount specified in the policy.

"CLEAN" CLAIM. A claim that is free of defect and impropriety, containing required substantiating documentation and also free of circumstances that require special treatment which may prevent timely payment.

CLINIC SERVICE. A functional division of a department of a Military Treatment Facility identified by a three-digit MEPRS code.

CMAC. CHAMPUS Maximum Allowable Charge

CMAC RATE TABLE. The rate table determines the payment for individual professional services and procedures identified by Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes which are used for inpatient and outpatient services.

CMS. Centers for Medicare and Medicaid Services formerly known as Health Care Financing Administration (HCFA).

CMS-1450/UB-92. The common claim form used by hospitals to bill for services rendered. Some managed care plans demand greater detail than is available on the UB-92, requiring the hospitals to send additional itemized bills. The UB-92 replaced the UB-82 in 1993.

CMS-1500. A claim form (Health Care Financing Administration) used by professionals to bill for services. Required by Medicare and generally used by private insurance companies and managed care plans.

COMPLIANCE. Accurately following the laws, rules and regulations that govern Medicare, Medicaid and other third party billing.

COMPONENT RATE TABLE. It is based on components that are comprised of professional, technical and global reimbursement rates.

CONSULTATION. A deliberation with a specialist concerning the diagnosis or treatment of a patient. To qualify as a consultation (for statistical measure) a written report to the requesting health care professional is required.

CONUS. Continental United States. United States territory, including the adjacent territorial waters located within the North American continent between Canada and Mexico. Alaska and Hawaii are not part of the CONUS.

COVERED SERVICE. This term refers to all of the medical services the enrollee may receive at no additional charge or with incidental copayments under the terms of the prepaid health care contract.

CPT. Current Procedural Terminology. A systematic listing and coding of procedures and services performed by a physician. Each procedure or service is identified with a five-digit code that simplifies the reporting of services.

CPT MODIFIER. A modifier is an addendum to procedure codes which indicates that a procedure has been altered by some specific circumstance but not changed in its definition.

DD7A. An outpatient treatment billing form used to report treatment rendered to pay patients. This billing form will include all billed charges for encounter-related procedures, services and/or billable standalone ancillary services.

DIAGNOSIS. A word used to identify a disease or problem from which an individual patient suffers or a condition for which the patient needs, seeks, or receives health care.

DMD. Doctor of Medical Dentistry

DME. Durable Medical Equipment. Medical equipment that is not disposable (i.e., is used repeatedly) and is only related to care for a medical condition. Examples would include wheelchairs, home hospital beds, and so forth. An area of increasing expense, particularly in conjunction with case management.

DMIS ID. Defense Medical Information System Identification Code. The Defense Medical Information System identification code for fixed medical and dental treatment

facilities for the Tri-Services, the U.S. Coast Guard, and USTFs. In addition, DMIS IDs are given for non-catchment areas, administrative units such as the Surgeon General's Office of each of the Tri-Services, and other miscellaneous entities.

DRG. Diagnosis Related Group. A grouping of Medicare inpatients used to determine the payment the hospital will receive for the admission of that type of patient. The group definition is based on diagnoses, procedures, presence of comorbidity/complication (CCs), age sex and discharge disposition.

E/M. Evaluation/Management

ELECTIVE CARE. Medical, surgical, or dental care that, in the opinion of professional authority, could be performed at another time or place without jeopardizing the patient's life, limb, health, or well being. Examples are surgery for cosmetic purposes, vitamins without a therapeutic basis, sterilization procedures, elective abortions, procedures for dental prosthesis, prosthetic appliances and so on.

EMERGENCY. Situation that requires immediate intervention to prevent the loss of life, limb, sight or body tissue or to prevent undue suffering.

ENCOUNTER. A face-to-face contact between a patient and a provider who has primary responsibility for assessing and treating the patient at a given contact, exercising independent judgment.

EOB. Explanation of Benefits. A statement provided by the health benefits administrator that explains the benefits provided, the allowable reimbursement amounts, any deductibles, coinsurance or other adjustments taken and net amount paid.

FAMILY MEMBER PREFIX (FMP). A two-digit number used to identify a sponsor or prime beneficiary or the relationship of the patient to the sponsor.

FORM LOCATOR (FL). There are 86 Form Locators on the CMS-1450/UB-92 Claim Form that are divided into four different categories. Each form locator represents a field on the UB-92 Claim Form where valid information is placed when submitting bills for reimbursement from the payers.

FY. Fiscal Year.

FRAUD. An intentional misrepresentation of the facts to deceive or mislead another.

GME. Graduate Medical Education. Full-time, structured medically related training, accredited by a national body (e.g., the Accreditation Council for Graduate Medical Education) approved by the commissioner of education and obtained after receipt of the appropriate doctoral degree.

HCPCS. Health Care Financing Administration's Common Procedural Coding System. A set of codes used by Medicare that describes services and procedures. HCPCS includes Current Procedural Terminology (CPT) codes, but also has codes for services not included in CPT, such as ambulance. While HCPCS is nationally defined, there is provision for local use of certain codes.

HEALTH CARE PROVIDER. A healthcare professional who provides health services to patients; examples include a physician, dentist, nurse, or allied health professional.

HOLD PERIOD. The Outpatient Itemized Billing System hold periods represent different timeframes patient encounter data are held in the source system before the claims are sent to TPOCS to be processed. The hold periods are: OHI 3-day hold, Laboratory and Radiology 7-day hold, Pharmacy 14-day hold and MSA 14-day hold.

ICD-9-CM. International Classification of Diseases, 9th Revision, Clinical Modification. A coding system for classifying diseases and operations to facilitate collection of uniform and comparable health information.

IMMUNIZATION. Protection of susceptible individuals from communicable diseases by administration of a living modified agent, a suspension of killed organisms or an inactivated toxin.

IMMUNIZATION PROCEDURE. The process of injecting a single dose of an immunizing substance. For a detailed discussion on counting immunization procedures, see DoD 6010.13-M (reference (a).

I&R. Invoice and Receipt. The I&R is a billing form used by MSA for inpatient hospitalization and to bill civilian emergencies for outpatient treatment. The I&R includes all billed charges for encounter related procedures, services and/or billable standalone ancillary services.

MAC. Medical Affirmative Claims. The Medical Affirmative Claims Program provide the statutory and regulatory authority to recover the reasonable value of medical care rendered for injuries or illness provided at the expense of the government to active duty members, dependents and retirees under circumstances creating third party tort liability.
MEPRS. Medical Expense and Performance Reporting System. A uniform reporting methodology designed to provide consistent principles, standards, policies, definitions and requirements for accounting and reporting of expense, manpower, and performance data by DoD fixed military medical and dental treatment facilities. Within these specific objectives, the MEPRS also provides, in detail, uniform performance indicators, common expense classification by work centers, uniform reporting of personnel utilization data by work centers, and a cost assignment methodology. (The two-digit MEPRS code identifies departments and the three-digit MEPRS code identifies clinic services.)

MSA. Medical Services Account. The MSA function involves billing and collecting funds from DoD beneficiaries, others authorized treatment in MTFs and civilian emergency patients for subsistence or medical services.

MTF. Military Treatment Facility. A military facility established for the purpose of furnishing medical and/or dental care to eligible individuals.

NCPDP. National Council of Prescription Drug Program.

NON-CMAC RATE TABLE. This table captures pricing for procedure codes at the local or State levels. Each State/locality does not have the same set of prevailing fees. There is a difference in the HCPCS/CPT codes with prevailing fees for each locality.

OCCASION OF SERVICE. A specific identifiable act or service involved in the medical care of a patient that does not require the assessment of the patient's condition nor the exercising of independent judgment as to the patient's care, such as a technician drawing blood, taking an x-ray, administering an immunization, issuance of medical

supplies and equipment; i.e., colostomy bags, hearing aid batteries, wheel chairs or hemodialysis supplies, applying or removing a cast and issuing orthotics. Pharmacy, pathology, radiology and special procedures services are also occasion of service and not counted as visits.

OCONUS. Outside the Continental United States.

OHI. Other Health Insurance.

OUTPATIENT. An individual receiving health care services for an actual or potential disease, injury or life style related problem that does not require admission to a medical treatment facility for inpatient care.

OUTPATIENT SERVICE. Care center providing treatment to patients who do not require admission as inpatients.

PATIENT. A sick, injured, wounded, or other person requiring medical or dental care or treatment.

PCM. Primary Care Manager. An individual (military or civilian) primary care provider, a group of providers, or an institution (clinic, hospital, or other site) who or which is responsible for assessing the health needs of a patient, and scheduling the patient for appropriate appointments (example: pediatric, family practice, ob-gyn) with a primary health care provider within the local MHS network.

PCP. Primary Care Physician. Generally applies to internists, pediatricians, family physicians and general practitioners and occasionally to obstetrician/gynecologists.

PRINCIPAL DIAGNOSIS. The condition established after study to be chiefly responsible for the patient's admission. This should be coded as the first diagnosis in the completed record.

PRINCIPAL PROCEDURE. The procedure that was therapeutic rather than diagnostic most related to the principal diagnosis or necessary to take care of a complication. This should be coded as the first procedure in the completed record.

PRIVILEGED PROVIDER. Privileged providers use E/M codes. He/she is essentially an independent practitioner who is granted permission to provide medical, dental and other patient care in the granting facility within defined limits based on the individual's education, professional license, experience, competence, ability, health and judgement. The provider had his/her qualifications reviewed by the credentialing review board, a scope of practice defined and a request for privileges approved by the privileging authority.

PROFESSIONAL COMPONENT. Professional services that have a professional component in which the physician reads and interprets the result of a test performed by a technician. The service will be designated with the use of a CPT-4 code and modifier – 26 on the CMS-1500 Claim Form.

PROFESSIONAL SERVICES. Any service or care rendered to an individual to include an office visit, X-ray, laboratory services, physical or occupational therapy, medical transportation, etc. Also any procedure or service that is definable as an authorized procedure from the CPT-4 coding system or the OCHAMPUS manuals.

PROVIDER. Healthcare professional or facility or group of healthcare professionals or facilities that provide healthcare services to patients.

RATE. Regular fee charged to all persons of the same patient category for the same service or care.

REFERRAL. Practice of sending a patient to another program or practitioner for services or advice that the referring source is not prepared or qualified to provide.

REVENUE CODE. It represents a specific accommodation, ancillary service or billing calculation and it is used on the UB-92 Claim Form. Revenue codes affect reimbursement, particularly for outpatient claims.

REVENUE CYCLE. It represents the beginning phase from the time a patient schedules an appointment for a clinic visit, to the end phase when the patient's account is closed after the MTF receives reimbursement.

TECHNICAL COMPONENT. It denotes services administered by medical staff such as a technician and will be recorded on the UB-92 Claim Form with modifier –TC.

TPCP. Third Party Collection Program

TPOCS. Third Party Outpatient Collection System. Compiles outpatient visit information from Ambulatory Data System (ADM), and ancillary testing or services information from the Composite Health Care System (CHCS). Using rate tables for billing services from DoD Comptroller, the system generates bills for accounts receivable, refunds or other health care insurance purposes.

UBU. Unified Biostatistical Utility. The committee is responsible for capturing and standardizing biostatistical data elements, definitions, data collection processes, procedure codes, diagnoses and algorithms across the MHS.

UCF. Universal Claim Form. A paper claim form used to bill pharmacy claims only.

UNBUNDLING. The practice of a provider billing for multiple components of service that were previously included in a single fee. For example, if dressing and instruments were included in a fee for a minor procedure, the fee for the procedure remains the same, but there are now additional charges for the dressings and instruments.

UNIT OF SERVICE. The number of days or units that were supplied for a particular listed CPT/HCPCS code will be populated in Item 24G. If only one service was provided, the number "1" should appear.

VISIT. Healthcare characterized by the professional examination and/or evaluation of a patient and the delivery or prescription of a care regimen.